QUESTIONNAIRES

Appendix C

NEPAL HEALTH FACILITY SURVEY - 2015

INVENTORY QUESTIONNAIRE

FACILITY IDENTIFICATION

001 NAME OF FACILITY _____

002 LOCATION OF FACILITY (TOWN/CITY/VILLAGE) _____

003 REGION . . . . . [ ]

004 DISTRICT . . . . . [ ][ ]

004A VDC/MUNICIPALITY . . . . . [ ][ ][ ]

004B WARD . . . . . [ ][ ]

005 FACILITY NUMBER . . . . . [ ][ ][ ][ ][ ]

006 TYPE OF FACILITY (COUNTRY SPECIFIC)

CENTRAL GOVERNMENT HOSPITAL	01
REGIONAL GOVERNMENT HOSPITAL	02
SUB-REGIONAL GOVERNMENT HOSPITAL	03
ZONAL GOVERNMENT HOSPITAL	04
DISTRICT GOVERNMENT HOSPITAL	05
OTHER HOSPITAL (NOT STATE-OWNED)	06
PRIMARY HEALTH CARE CENTER (PHCC)	07
HEALTH POST (HP)	08
SUB-HEALTH POST (SHP)	09
URBAN HEALTH CENTER	10
HTC (STAND ALONE)	11
OTHER PUBLIC HOSPITAL	12

007 MANAGING AUTHORITY (OWNERSHIP)

GOVERNMENT/PUBLIC	1
NGO/PRIVATE NOT-FOR-PROFIT	2
PRIVATE-FOR-PROFIT	3
MISSION/FAITH-BASED	4

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY [ ][ ] MONTH [ ][ ] YEAR 2015
INTERVIEWER NAME	_____	_____	_____	INT. NUMBER [ ][ ][ ]
RESULT	_____	_____	_____	RESULT [ ]

RESULT CODES (LAST VISIT):
1 = FACILITY COMPLETED
2 = FACILITY RESPONDENTS NOT AVAILABLE
3 = POSTPONED / PARTIALLY COMPLETED
4 = FACILITY REFUSED
5= FACILITY CLOSED / NOT YET FUNCTIONAL
6 = OTHER _____
(SPECIFY)

TOTAL NUMBER OF PROVIDER INTERVIEWS AND OBSERVATIONS

		TOTAL # CLIENT VISITS
TOTAL NUMBER OF PROVIDERS INTERVIEWED.		
TOTAL NUMBER OF ANC OBSERVATIONS		
TOTAL NUMBER OF FAMILY PLANNING OBSERVATIONS.		
TOTAL NUMBER OF SICK CHILD OBSERVATIONS		
TOTAL NUMBER OF POSTPARTUM EXIT INTERVIEWS.		

FACILITY GEOGRAPHIC COORDINATES

SET DEFAULT SETTINGS FOR GPS UNIT

- SET COORDINATE SYSTEM TO LATITUDE / LONGITUDE
- SET COORDINATE FORMAT TO DECIMAL DEGREE
- SET DATUM TO WGS84

STAND IN A LOCATION AT THE ENTRANCE OF THE FACILITY WITH PLAIN VIEW OF THE SKY

1 TURN GPS MACHINE ON AND WAIT UNTIL SATELITE PAGE CHANGES TO "POSITION"

2 WAIT 5 MINUTES

3 PRESS "MARK"

4 HIGHLIGHT "WAYPOINT NUMBER" AND PRESS "ENTER"

5 ENTER X-DIGIT FACILITY CODE / FACILITY NUMBER

6 HIGHLIGHT "SAVE" AND PRESS "ENTER"

7 PAGE TO MAIN MENU, HIGHLIGHT "WAYPOINT LIST" AND PRESS "ENTER"

8 HIGHLIGHT YOUR WAYPOINT

9 COPY INFORMATION FROM WAYPOINT LIST PAGE

10 WRITE ELEVATION [ALTITUDE]

BE SURE TO COPY THE WAYPOINT NAME FROM THE WAYPOINT LIST PAGE TO VERIFY THAT YOU ARE ENTERING THE CORRECT WAYPOINT INFORMATION ON THE DATA FORM

010 WAYPOINT NAME (FACILITY NUMBER)	WAYPOINT NAME
012 LATITUDE	N/S . . . . . a DEGREES/DECIM b . c
013 LONGITUDE	E/W . . . . . a DEGREES/DECIM b . c

CONSENT

FIND THE MANAGER, THE PERSON IN-CHARGE OF THE FACILITY, OR THE MOST SENIOR HEALTH WORKER RESPONSIBLE FOR CLIENT SERVICES WHO IS PRESENT AT THE FACILITY. READ THE FOLLOWING GREETING:

Good day! My name is _____. We are here on behalf of NEW ERA conducting a survey of health facilities to assist the government in knowing more about health services in NEPAL

Now I will read a statement explaining the study.

Your facility was selected to participate in this study. We will be asking you questions about various health services. Information collected about your facility during this study may be used by NEW ERA, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor the name of the health facility, nor the names of any other health workers who participate in this study will be included in the dataset or in any report. Still, we are asking for your help in order to collect this information.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____

INTERVIEWER'S SIGNATURE INDICATING CONSENT OBTAINED

		2 0 1	
DAY	MONTH	YEAR	

100	May I begin the interview?	YES . . . . . 1 NO 2	→ STOP
101	INTERVIEW START TIME	HOURS : MINUTES	
101A*	Is this facility a CEmONC, BEmONC or Birthing center based on government endorsement not on fonctionality?	CEmONC. . . . . 1 BEmONC. . . . . 2 BIRTHING CENTER. . . . . 3 NONE OF THE ABOVE. 8	

EXPLAIN TO THE RESPONDENT AT THE START OF THIS INTERVIEW THAT THERE ARE QUESTIONS ON MANAGEMENT MEETINGS AND QUALITY ASSURANCE ACTIVITIES THAT REQUIRE LOOKING AT RECORDS OF THOSE MEETINGS AND ACTIVITIES. IT WILL THEREFORE BE HELPFUL IF RECORDS PERTAINING TO MANAGEMENT MEETINGS AND QUALITY ASSURANCE ACTIVITIES ARE GATHERED, IF THEY ARE NOT READILY AVAILABLE AT THE LOCATION WHERE YOU ARE CONDUCTING THE INTERVIEW.

EXPLAIN ALSO THAT THERE IS A SUBSECTION ON HEALTH STATISTICS (NUMBER OF OUTPATIENT VISITS AND INPATIENT DISCHARGES) FOR THE IMMEDIATE PAST ONE COMPLETE MONTH. IT WILL BE HELPFUL TO ALSO START GATHERING SUCH INFORMATION IF INFORMATION IS NOT READILY AVAILABLE WHERE THE INTERVIEW IS BEING CONDUCTED.

NOTE!!!!

THANK THE RESPONDENT AT THE END OF EACH SECTION OR SUBSECTION BEFORE PROCEDING TO THE NEXT DATA COLLECTION POINT

MODULE 1: GENERAL INFORMATION AND SERVICE AVAILABILITY

SECTION 1: GENERAL SERVICE AVAILABILITY AND INPATIENT SERVICES

SERVICE AVAILABILITY

		YES	NO	YES, BUT RESPONDENT NOT AVAILABLE	DONE
102*	Does this facility offer any of the following client services? In other words, is there any location in this facility where clients can receive any of the following services:				
01	Child vaccination services, either at the facility or as outreach.	1	2	3	☐
02	Growth monitoring services, either at the facility or as outreach	1	2	3	☐
03	Curative care services for children under age 5, either at the facility or as outreach	1	2	3	☐
04	Any family planning services-- including modern methods, fertility awareness methods (natural family planning), male or female surgical sterilization	1	2	3	☐
05	Antenatal care (ANC) services	1	2	3	☐
06	Services for the prevention of mother-to-child transmission of HIV, either with ANC or delivery services	1	2	3	☐
07*	Delivery and Newborn care	1	2	3	☐
08	Diagnosis or treatment of malaria	1	2	3	☐
09	Diagnosis or treatment of STIs, excluding HIV	1	2	3	☐
10	Diagnosis, treatment prescription or treatment follow-up for TB	1	2	3	☐
11	HIV testing and / or counseling services	1	2	3	☐
12	HIV/AIDS antiretroviral prescription or antiretroviral treatment follow-up services	1	2	3	☐
13	HIV/AIDS care and support services, including treatment of opportunistic infections and provision of palliative care	1	2	3	☐
14	Diagnosis or management of non-communicable diseases, specifically diabetes cardiovascular diseases, and chronic respiratory conditions in adults.	1	2	3	☐
15	Minor surgical services, such as incision and drainage of abscesses and suturing of lacerations that do not require the use of a theatre?	1	2	3	☐
16	Cesarean delivery (Cesarean section)	1	2	3	☐
17	Laboratory diagnostic services, including any rapid diagnostic testing.	1	2	3	☐
18	Blood typing services	1	2	3	☐
19	Blood transfusion services	1	2	3	☐
20*	Diagnosis or treatment of Kalaazar / Leishmaniasis	1	2	3	☐
21*	Management of Snake Bite	1	2	3	☐
22*	Management of Dog Bite/Rabies	1	2	3	☐

INPATIENT SERVICES

110	Does this facility routinely provide in-patient care?	YES. . . . . 1 NO. 2	→ 112
111	Does this facility have beds for overnight observation?	YES. . . . . 1 NO. 2	→ 200
112	Excluding any delivery and/or maternity beds, how many ***(overnight)*** **or** ***(in-patient)*** beds in total does this facility have, both for adults and children? IF 1000 OR MORE INPATIENT BEDS, ENTER "995"	# OF OVERNIGHT/ INPATIENT BEDS . . . . . ☐☐☐ DON'T KNOW 998	

SECTION 2: GENERAL FILTER QUESTIONS

PROCESSING OF INSTRUMENTS

200	I have a few questions about how surgical instruments, such as speculums, forceps, and other metal equipment are processed for re-use in this facility. Are instruments that are used in the facility processed (i.e., sterilized or high-level disinfected) for re-use?	YES. . . . . 1 NO. 2	→ 210
201	Is the final processing done in this facility, outside this facility, or both?	ONLY IN THIS FACILITY. . . . . 1 BOTH IN THIS FACILITY AND OUTSIDE . . . . . 2 ONLY AT AN OUTSIDE FACILITY. 3	

STORAGE OF MEDICINES

210	Does this facility store any medicines (including ARVs), vaccines or contraceptive commodities? PROBE	YES. . . . . 1 FACILITIES STOCKS NO MEDICINES. . . . 2	→ 300
211	**CHECK Q102.04** FAMILY PLANNING SERVICES AVAILABLE ☐ ↓	NO FAMILY PLANNING SERVICES ☐ →	213
212	Are contraceptive commodities generally stored in the family planning service area, or are they stored in a common area with other medicines?	STORED IN FP SERVICE AREA. . . . . 1 STORED WITH OTHER MEDICINES. . . . . 2 FP COMMODITIES NOT STOCKED. 3	
213	**CHECK Q102.10** TUBERCULOSIS SERVICES AVAILABLE ☐ ↓	NO TUBERCULOSIS SERVICES ☐ →	215
214	Are medicines for the treatment of TB generally stored in the TB service area or are they stored in a common area with other medicines?	STORED IN TB SERVICE AREA. . . . . 1 STORED WITH OTHER MEDICINES. . . . . 2 TB MEDICINES NOT STOCKED. 3	
215	**CHECK Q102.06 AND Q102.12** ARV TREATMENT OR PMTCT SERVICES AVAILABLE ☐ ↓	NEITHER ARV TREATMENT NOR PMTCT SERVICES AVAILABLE ☐ →	300
216*	Are antiretroviral (ARV) medicines for ART generally stored in the ARV treatment service area, in the PMTCT service area, or are they stored in a common area with other medicines?	ARV FOR ART STORED IN ART SERVICE 1 ARV FOR ART STORED WITH OTHER ME 2 ARV MEDICINES NOT STOCKED. . . . . 3 ARV FOR ART STORED IN PMTCT SERVICE A 4 ARV FOR ART STORED IN ART AND PMTCT SERVICE AREA. 5	

MODULE 2: GENERAL SERVICE READINESS

SECTION 3: 24-HOUR STAFF COVERAGE - INFRASTRUCTURE EXTERNAL SUPERVISION - USER FEES - SOURCES OF REVENUE

24-HOUR STAFF COVERAGE

300*	Is there a health care worker present at the facility at all times, or officially on call for the facility at all times (24 hours a day) for emergencies?	YES, 24-HR STAFF. . . . . 1 NO 24-HOUR STAFF. 2	→ 310
301	Is there a duty schedule or call list for 24-hour staff coverage?	YES . . . . . 1 DUTY SCHEDULE NOT MAINTAINED. . . . 2	→ 310
302	May I see the duty schedule or call list for 24-hour staff coverage?	SCHEDULE OBSERVED. . . . . 1 SCHEDULE REPORTED NOT SEEN. 2	

COMMUNICATION

310	Does this facility have a ***land line telephone*** that is available to call outside at all times client services are offered? CLARIFY THAT IF FACILITY OFFERS 24-HOUR EMERGENCY SERVICES, THEN THIS REFERS TO 24-HOUR AVAILABILITY.	YES . . . . . 1 NO. 2	→ 313
311	May I see the land line telephone?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	
312	Is it functioning? ACCEPT REPORTED RESPONSE	YES. . . . . 1 NO. 2	
313*	Does this facility have a ***cellular telephone,*** or a private cellular phone that is supported by the facility?	YES . . . . . 1 NO. 2	→ 319
314	May I see either the facility-owned cellular phone or the private cellular phone that is supported by the facility?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	
315	Is it functioning? ACCEPT REPORTED RESPONSE	YES. . . . . 1 NO. 2	
319	Does this facility have ***a computer ?***	YES. . . . . 1 NO. 2	→ 322
320	May I see the computer?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	
321	Is it functioning? ACCEPT REPORTED RESPONSE	YES. . . . . 1 NO. 2	
322	Is there access to email or internet via computer and/or mobile phone within the facility? ACCEPT REPORTED RESPONSE.	YES. . . . . 1 NO. 2	→ 330
323	Is the email or internet routinely available for ***at least 2 hours*** on days that client services are offered? ACCEPT REPORTED RESPONSE.	YES. . . . . 1 NO. 2	

SOURCE OF WATER

330	What is the *most commonly used* source of water for the facility *at this time?* OBSERVE THAT WATER IS AVAILABLE FROM SOURCE OR IN THE FACILITY ON THE DAY OF THE VISIT. E.G., CHECK THAT THE PIPE IS FUNCTIONING.	PIPED INTO FACILITY. . . . . 01 PIPED ONTO FACILITY GROUNDS. . . . . 02 PUBLIC TAP/STANDPIPE. . . . . 03 TUBEWELL/BOREHOLE . . . . . 04 PROTECTED DUG WELL . . . . . 05 UNPROTECTED DUG WELL . . . . . 06 PROTECTED SPRING . . . . . 07 UNPROTECTED SPRING . . . . . 08 RAINWATER . . . . . 09 BOTTLED WATER . . . . . 10 CART W/SMALL TANK/DRU . . . . . 11 TANKER TRUCK . . . . . 12 SURFACE WATER (RIVER/DAM/LAKE/POND). . . . . 13 OTHER (SPECIFY)_____ 96 DON'T KNOW . . . . . 98 NO WATER SOURCE 00	→ 332 → 332 → 332 → 340
331	Is water outlet from this source available onsite, within 500 meters of the facility, or beyond 500M of facility? REPORTED RESPONSE IS ACCEPTABLE	ONSITE. . . . . 1 WITHIN 500M OF FACILITY. . . . . 2 BEYOND 500M OF FACILITY. 3	
332	Is there routinely a time of year when the facility has a severe shortage or lack of water?	YES. . . . . 1 NO. 2	

POWER SUPPLY

340	Is this facility connected to the national electricity grid?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	 → 342
341	During the past 7 days, was electricity (excluding any back-up generator) available during the times when the facility was open for services, or was it ever interrupted ***for more than 2 hours at a time?*** CONSIDER ELECTRICITY TO BE ALWAYS AVAILABLE IF INTERUPTED FOR LESS THAN 2 HOURS AT A TIME.	ALWAYS AVAILABLE. . . . . 1 SOMETIMES INTERRUPTED. . . . . 2 DON'T KNOW. 8	
342	Does this facility have other sources of electricity, such as a generator or solar system?	YES. . . . . 1 NO OTHER SOURCE. 2	 → 350
343*	What other sources of electricity does this facility have? PROBE FOR ANSWERS AND CIRCLE ALL THAT APPLY	FUEL-OPERATED GENERATOR. . . . . A BATTERY-OPERATED GENERATOR. . . . B SOLAR SYSTEM. . . . . C INVERTOR . . . . . D	
344*	**CHECK Q343** GENERATOR USED (EITHER "A" OR "B" CIRCLED) ☐	GENERATOR NOT USED (NEITHER "A" NOR "B" CIRCLED) ☐→	346A
345*	Is the generator functional? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	 → 346A
346*	Is fuel (or a charged battery) available today for the generator ? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
346A*	**CHECK Q343** INVERTOR USED ("D" CIRCLED) ☐	INVERTOR NOT USED ("D" NOT CIRCLED) ☐→	350
346B*	Is the invertor functional? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	

EXTERNAL SUPERVISION

350	Does this facility receive any external supervision, e.g., from the district, regional, zonal or national office?	YES. . . . . 1 NO. 2	→ 360
351*	When was the last time a supervisor from outside this facility came here on a supervisory visit? Was it within the past 4 months or more than 4 months ago?	WITHIN THE PAST 4 MONTHS . . . . . 1 MORE THAN 4 MONTHS AGO. 2	→ 360
351A*	During the past 4 months, how frequently has this facility received a visit from supervisory authorities ?	WEEKLY. . . . . 1 MONTHLY. . . . . 2 EVERY TWO MONTHS. . . . . 3 ONCE IN FOUR MONTHS. . . . . 4 OTHER (SPECIFY)_____ 6	

		YES	NO	DON'T KNOW
352*	The last time during the past 4 months that a supervisor from outside the facility visited, did he or she do any of the following:			
01	Use a checklist to assess the quality of available health services data?	1	2	8
02	Discuss performance of the facility based on available health services data?	1	2	8
03	Help the facility make any decisions based on available health services data?	1	2	8

USER FEES

360*	Does this facility have any ***routine user-fees or charges*** for client services, including charges for health cards and for client registration?	YES. . . . . 1 NO. 2	→ 370
361	Does the facility charge a fixed fee that covers all services that a client receives, or are there separate fees for different components of the services provided by the facility? PROBE.	FIXED FEE COVERING ALL SERVICES . . . . . 1 NO, CHARGE FEE FOR SEPARATE ITEMS. . . 2	→ 363

362*	Does this facility have a fee for the following items: READ OUT EACH RESPONSE CATEGORY AND CIRCLE APPROPRIATELY	YES	NO	N/A	
01*	CLIENT HEALTH CARD / REGISTRATION.	1	2	5	
03	CONSULTATION.	1	2	5	
04	MEDICINES (OTHER THAN ARVs)	1	2	5	
05*	ROUTINE VACCINES.	1	2	5	
06	CONTRACEPTIVE COMMODITIES.	1	2	5	
07	NORMAL DELIVERIES	1	2	5	
08	SYRINGES AND NEEDLES.	1	2	5	
09	CESAREAN SECTION	1	2	5	
10	HIV DIAGNOSTIC TEST	1	2	5	
11	MALARIA RAPID DIAGNOSTIC TEST	1	2	5	
12	MALARIA MICROSCOPY	1	2	5	
13	OTHER LABORATORY TESTS	1	2	5	
14	ARV FOR TREATMENT	1	2	5	
15	ARV FOR PMTCT.	1	2	5	
16	MINOR SURGICAL PROCEDURES.	1	2	5	
17*	HEMOGLOBIN TEST	1	2	5	
18*	CHEST X-RAY	1	2	5	
19*	GENERAL BED CHARGE FOR INPATIENT STAY	1	2	5	
363	Are the official fees posted or displayed so that the client can easily see them?	YES. . . . . 1 NO POSTED FEES. 2			→ 365
364*	May I see the posted fees? REVIEW THE POSTED FEES AGAINST THE LIST OF ITEMS IN Q362 TO DETERMINE IF ALL FEES ARE POSTED	OBSERVED, ALL FEES POSTED. . . . . 1 OBSERVED, SOME BUT NOT ALL FEES. . 2			
365	What is the procedure if a client is unable to pay for any of the fees associated with health care provided in this facility? CIRCLE ALL THAT APPLY. PROBE TO ARRIVE AT APPROPRIATE RESPONSE	FEE EXEMPTED/DISCOUNTED, NO PAYMENT EXPECTED. . . . . A FEE EXEMPTED/DISCOUNTED, PAYMENT EXPECTED LATER. . . . . B SERVICE NOT PROVIDED, ASKED TO COME BACK WHEN ABLE TO PAY. . . C ACCEPT PAYMENT IN-KIND. . . . . D OTHER (SPECIFY)_____ X			

SOURCES OF INCOME

		(A) REVENUE			(B) AMOUNT IN RUPEES
370*	Now, I would like to ask about the sources of revenue or funding for this facility. Tell me if the facility received any revenue or funding from any of the listed sources during the 2013 - 2014 financial year. If yes, I would like to know the amount. If **someone else** is more appropriate to provide financial information, please feel free to invite that person or refer me to that person.	YES	NO	DON'T KNOW	IF AMOUNT IS NOT KNOWN ENTER "999999998"
01	MINISTRY OF HEALTH AND POPULATION	1 → b	2 → 02	8 → 02	
02	MINISTRY OF FEDERAL AFFAIRS AND LOCAL DEVELOPME (MOFALD) [e.g. VDC, DDC, MUNICIPALITY]	1 → b	2 → 03	8 → 03	
03	SERVICE CHARGE	1 → b	2 → 04	8 → 04	
04	TRAINING COLLEGES (NURSING OR MEDICAL)	1 → b	2 → 05	8 → 05	
05	ALL OTHER SOURCES	1 → b	2 → 370C	8 → 370C	

370C	**CHECK Q006** FACILITY IS NOT A PRIVATE HOSPITAL NEITHER AN URBAN HEALTH CENTER NOR A HTC STAND ALONE (NEITHER "06" NOR "10" NOR "11"CIRCLED)			FACILITY IS EITHER A PRIVATE HOSPITAL OR AN URBAN HEALTH CENTER OR A HTC STAND ALONE (EITHER "06" OR "10" OR "11" CIRCLED)				400
370D	Was there any financial and social audit conducted/ held in the following fiscal years?	(A) FY 2068/69		(B) FY 2069/70		(C) FY 2070/71		
		YES	NO	YES	NO	YES	NO	
01	Financial Audit	1	2	1	2	1	2	
02	Social Audit	1	2	1	2	1	2	

SECTION 4: STAFFING - MANAGEMENT - CLIENT OPINION- QUALITY ASSURANCE - TRANSPORT - HMIS AND HEALTH STATISTICS

STAFFING

400* For eacn of the following occupational categories / technical qualifications, please tell me
A) How many are sanctioned by MOHP and how many are sanctioned by the local government.
B) The total workforce currently working in this facility, regardless of source. They may be filled by MOHP, filled by local governement, filled by contract or deputation, or employed direcly by the facility.
C) Fially, tell me how many are filled by MOHP specifically, how many are filled by local government specifically, how many are contracted or on deputation, and how many are employed directly by the facility, if any.

	OCCUPATIONAL CATEGORIES / TECHNICAL QUALIFICATION	(A) SANCTIONED POSTS		(B) TOTAL WORKFORCE	(C) FILLED BY			
		(AA) **MOHP** APPLICABLE ONLY IN GOVERNMENT FACILITIES	(AB) **LOCAL GOVERNMENT** APPLICABLE ONLY IN GOVERNMENT HOSPITALS	**(ASSIGNED BY MOHP, LOCAL GOVERNMENT, CONTRACTED, DEPUTATION, OR EMPLOYED DIRECTLY BY FACILITY)**	(CA) **MOHP** APPLICABLE ONLY IN GOVERNMENT FACILITIES	(CB) **LOCAL GOVERNMENT** APPLICABLE ONLY IN GOVERNMENT HOSPITALS	(CC) **CONTRACTED OR DEPUTATION**	(CD) **EMPLOYED DIRECTLY BY FACILITY**
01	GENERALIST [NON-SPECIALIST]							
02	GYNECOLOGIST / OBSTETRICIAN							
03	ANESTHESIOLOGIST							
04	PATHOLOGIST							
05	GENERAL SURGEON							
06	PEDIATRICIAN							
07	OTHER SPECIALISTS MEDICAL DOCTORS							
08	MEDICAL OFFICER (MBBS, BDS)							
09	ANESTHETIC ASSISTANT							
10	NURSE (MN, BSC NURSE, BN, PCL) / AUXILLARY NURSE MIDWIFE (ANM)							
11	LABORATORY TECHNOLOGIST/OFFICER/ LABORATORY TECHNICIAN / LABORATORY ASSISTANT							
12	HEALTH ASSISTANT (HA) / AHW / SAHW / PUBLIC HEALTH INSPECTOR							
13	PHARMACIST							
14	RADIOGRAPHER / DARK ROOM ASSISTANT							
15	PHYSIOTHERAPIST / PHYSIOTHERAPY ASSISTANT							
16	COUNSELOR WITH CLINICAL QUALIFICATION (STAND-ALONE HTC ONLY)							
17	COUNSELOR WITHOUT CLINICAL QUALIFICATION (STAND-ALONE HTC ONLY)							
18	OTHER CLINICAL STAFF NOT LISTED ABOVE (E.G., DIETICIAN)							
19	NON- CLINICAL STAFF / NO TECHNICAL QUALIFICATION							
20	SUM THE NUMBER OF STAFF REPORTED. VERIFY AND CORRECT THE TOTALS							

SECTION 4: STAFFING - MANAGEMENT - CLIENT OPINION QUALITY ASSURANCE - TRANSPORT - HMIS AND HEALTH STATISTICS

MANAGEMENT MEETINGS

NOTIFY THE RESPONDENT THAT THIS SUBSECTION REQUIRES LOOKING AT RECORDS OF MEETINGS. IT WILL THEREFORE BE HELPFUL IF SUCH RECORDS ARE GATHERED BEFORE PROCEEDING WITH THE INTERVEIW.

410*	Does this facility have routine facility management meetings? (Staff Meeting)	YES. . . . . 1 NO 2	→417
411	How frequently do these facility management meetings take place?	MONTHLY OR MORE FREQUENTLY. . . . . 1 ONCE EVERY 2-3 MONTHS. . . . . 2 ONCE EVERY 4-6 MONTHS. . . . . 3 LESS FREQ. THAN EVERY 6 MONTHS. . . . . 4 DON'T KNOW. 8	→417
412	Does the facility maintain official records of facility management meetings?	YES. . . . . 1 NO, RECORDS NOT MAINTAINED 2	→417
413	May I see the records or minutes from the most recent meeting that took place within the last 6 months?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	→417
414	REVIEW THE RECORDS OR MINUTES OF THE MOST RECENT MEETING NO OLDER THAN 6 MONTHS AND CIRCLE THE LETTER FOR ANY OF THE LISTED TOPICS THAT ARE MENTIONED IN THE REPORT.	HMIS DATA QUALITY. . . . . A HMIS REPORTING. . . . . B TIMELINESS OF HMIS REPORTING. . . . . C QUALITY OF SERVICES. . . . . D CLIENT UTILIZATION. . . . . E DISEASE DATA. . . . . F EMPLOYMENT CONDITIONS (E.G., SALARIES, DUTY SCHEDULES). . . . . G FINANCES OR BUDGET. . . . . H OTHER _____ X NONE OF THE ABOVE. . . . . Y	→417
415*	Did the facility make any action plan based on what was discussed at the last meeting and covered in this report?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	→417
416	Has the facility taken any follow-up action regarding the decisions made during the last meeting?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
417*	Are there any *routine* meetings about facility activities or management issues that include both facility staff and community / community committee members?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	→420A
418*	How frequently are routine meetings held with both facility staff and community / community committee members?	MONTHLY OR MORE FREQUENTLY. . . . . 1 EVERY 2-3 MONTHS. . . . . 2 EVERY 4-6 MONTHS. . . . . 3 LESS FREQ. THAN EVERY 6 MONTHS. . . . . 4 DON'T KNOW. 8	→420A
419*	Is an official record of the meetings with both facility staff and community members maintained?	YES. . . . . 1 NO, RECORDS NOT MAINTAINED 2	→420A
420	May I see the records or minutes from the most recent meeting that took place within the last 6 months?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

420X	**CHECK Q006** FACILITY TYPE IS NEITHER AN URBAN HEALTH CENTER NOR A HTC STAND ALONE (NEITHER "10" NOR "11"CIRCLED) ☐			FACILITY TYPE IS EITHER AN URBAN HEALTH CENTER OR A HTC STAND ALONE (EITHER "10" OR "11" CIRCLED) ☐	→430
420A	Does this health facility have a citizen charter? IF YES ASK TO SEE THE CITIZEN CHARTER			YES, CLEARLY READABLE. . . . . 1 YES, BUT NOT CLEARLY READABLE. . . . . 2 NO. 3	→420D
420B	Where is the citizen charter placed? OBSERVE			OUTSIDE BUILDING-VISIBLE PLACE. . . . . 1 OUTSIDE BUILDING- NOT VISIBLE PLACE . . 2 INSIDE BUILDING- VISIBLE PLACE. . . . . 3 INSIDE BUILDING- NOT VISIBLE PLACE. . . . 4	
420D	Does this facility has a management committee?			YES. . . . . 1 NO 2	→430
420E	When was this facility management Committee/HFOMC/HDC formed?			YEAR . . . . . ☐☐☐☐ DON'T KNOW. 9998	
420F	How many members are there in total? How many of these members are male, female, Dalit, Janajati?	(A) TOTAL	(B) MALE	(C) FEMALE	
01	Members (including Chairperson and Member Secretary)	☐☐ DK 98	☐☐ DK 98	☐☐ DK 98	
02	Dalit	☐☐ DK 98	☐☐ DK 98	☐☐ DK 98	
03	Janjajati	☐☐ DK 98	☐☐ DK 98	☐☐ DK 98	
04	Other caste group	☐☐ DK 98	☐☐ DK 98	☐☐ DK 98	

CLIENT OPINION AND FEEDBACK

430*	Does this facility have any system for collecting clients' opinions / feedback about the health facility or its services?	YES. . . . . 1 NO 2	→440
431*	Please tell me all the methods that this facility uses to elicit client opinion / feedback. CIRCLE ALL METHODS MENTIONED AND PROBE: ANY MORE?	SUGGESTION BOX. . . . . A CLIENT SURVEY FORM. . . . . B CLIENT INTERVIEW FORM. . . . . C OFFICIAL MEETIING WITH COMMUNITY LEADERS. . . . . D INFORMAL DISCUSSION WITH CLIENTS OR THE COMMUNITY. . . . . E EMAIL. . . . . F FACILITY'S WEBSITE. . . . . G LETTERS FROM CLIENTS/COMMUNITY. . . . . H OTHER_____ X DON'T KNOW. . . . . Z	→440
432*	Is there a procedure for reviewing or reporting on clients' opinion / feedback? IF YES, ASK TO SEE A REPORT OR FORM ON WHICH DATA ARE COMPILED OR DISCUSSION IS REPORTED	YES . . . . . 1 NO PROCEDURE/REPORT . . . . . 2 DON'T KNOW. 8	→440
433*	May I see a report on the review of client opinion / feedback, or any document on such a review?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

QUALITY ASSURANCE

NOTIFY THE RESPONDENT THAT THIS SUBSECTION REQUIRES LOOKING AT RECORDS OF QUALITY ASSURANCE ACTIVITIES. IT WILL THEREFORE BE HELPFUL IF SUCH RECORDS ARE GATHERED BEFORE PROCEEDING WITH THE INTERVEIW.

440	Does this facility routinely carry out quality assurance activities? An example may be facility-wide review of mortality, or periodic audit of registers.	YES. . . . . 1 NO . . . . . 2 DON'T KNOW 8	→450
441*	Is there an official record of any quality assurance activities carried out during the last fiscal year?	YES. . . . . 1 NO, RECORDS NOT MAINTAINED 2	→442A
442	May I see a record of any quality assurance activity? A REPORT OR MINUTES OF A QA MEETING, A SUPERVISORY CHECKLIST, A MORTALITY REVIEW, AN AUDIT OF RECORDS OR REGISTERS ARE ALL ACCEPTABLE.	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	
442A*	Do you have the quality assurance guidelines (Swastha Sewako Gunastar Sudhar Padhatee-2066)?	YES. . . . . 1 NO 2	→442C
442B	May I see the quality assurance guidelines?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	
442C*	Do you have a quality assurance action plan ?	YES. . . . . 1 NO 2	→450
442D	May I see the quality assurance action plan ?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	

TRANSPORT FOR EMERGENCIES

450	Does this facility have a ***functional ambulance*** or other vehicle for emergency transportation for clients that is stationed at this facility and that operates from this facility? IF YES, ASK: Is a driver available to operate the ambulace?	YES. . . . . 1 NO. . . . . 2 YES, AMBULANCE AVAILABLE, BUT NO DRIVER TO OPERATE. 3	→452 →452
451	May I see the ambulance (or other vehicle)?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	→453
452*	Does this facility have access to an ambulance or other vehicle for emergency transportation for clients that is stationed at another facility or that operates from another health facility?	YES. . . . . 1 NO. 2	→460 →453A
453*	Is fuel available today? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	→460
453A*	In case of medical emergencies, what is the most common means by which clients are transported from this facility to the nearest referral facility?	STRETCHER . . . . . 01 DOKO . . . . . 02 RICKSHAW / BICYCLE. . . . . 03 AUTO VEHICLE. . . . . 04 HAND CART/WHEELBARROW . . . . . 05 ANIMAL-DRIVEN CART/TANGA . . . . . 06 HIRED AMBULANCE . . . . . 07 OTHER. . . . . 96 NONE OF THE ABOVE. 00	

HMIS

FIND THE PERSON RESPONSIBLE FOR HEALTH INFORMATION SYSTEMS. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE ASSESSMENT BEFORE PROCEEDING WITH QUESTIONS IN THIS SUBSECTION. NOTIFY THE RESPONDENT THAT THIS SUBSECTION REQUIRES THAT SOME STATISTICS ARE GATHERED, FROM RECORDING REGISTERS AND MONTHLY REPORTS IF SUCH INFORMATIO IS NOT READILY AVAILABLE AT THE LOCATION WHERE THE INTERVIEW IS BEING CONDUCTED.

460	Does this facility have a system in place to regularly collect health services data?	YES. . . . . 1 NO. 2	
461	Does this facility regularly compile any reports containing health services information?	YES. . . . . 1 NO. 2	→464
462	How frequently are these reports compiled?	MONTHLY OR MORE OFTEN. . . . . 1 EVERY 2-3 MONTHS. . . . . 2 EVERY 4-6 MONTHS . . . . . 3 LESS OFTEN THAN EVERY 6 MONTHS 4	
462A*	Does this health facility use HMIS forms (9.3- if SHP, HP, PHC), (9.4 - if Public hospital), (9.5- if non- state health facility) for HMIS reporting? THESE FORMS ARE HEALTH FACILITY SPECIFIC. READ OUT THE FORM THAT CORRESPONDS TO THE FACLITY TYPE.	YES, USE HMIS 9.3. . . . . 1 YES, USE HMIS 9.4. . . . . 2 YES, USE HMIS 9.5. . . . . 3 NO, USE A SEPARATE FORM. . . . . 4 DO NOT REPORT TO HMIS 5	→464
463*	May I see a copy of this health facility's HMIS report for the last completed calendar month [MONTH] ?	RECORD OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
464*	Does this facility have a designated person, who is responsible for health services data in this facility?	YES. . . . . 1 NO. 2	→465A
464A*	Has the responsible person for health services data received formal training on recording and reporting?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
465A*	**CHECK Q006** FACILITY IS NOT A PRIVATE HOSPITAL NOR A HTC STAND ALONE (NEITHER "06" NOR "11"CIRCLED) ↓	FACILITY IS EITHER A PRIVATE HOSPITAL OR A HTC STAND ALONE (EITHER "06" OR "11" CIRCLED) →	470
465B	Does this facility have the HMIS tool book "Recodring and Reporting Tools in HMIS, 2070"?	YES. . . . . 1 NO. 2	→465D
465C	May I see the HMIS tool kit "Recodring and Reporting Tools in HMIS, 2070"?	RECORD OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
465D	Does this health facility have a copy of the "HMIS User Manual, 2070" available in this health facility?	YES. . . . . 1 NO. 2	→465F
465E	May I see a copy of the "HMIS User Manual, 2070"?	RECORD OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
465F	Does this health facility have a copy of the "HMIS Indicators 2070" booklet available in this facility?	YES. . . . . 1 NO. 2	→465H
465G	May I see a copy of the "HMIS Indicators, 2070" booklet?	RECORD OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
465H	Does this health facility use the monthly monitoring sheet? If so, has the health facility updated the monthly monitoring sheet of the last three months? OBSERVE AND VALIDATE IF THE MONITORING SHEET IS UPDATED FOR THE LAST 3 MONTHS.	YES, UPDATED FULLY. . . . . 1 YES, UPDATED PARTIALLY. . . . . 2 YES, NOT UPDATED AT ALL. . . . . 3 NOT AVAILABLE. . . . . 4 NOT USED. 5	

HEALTH STATISTICS

NOTIFY THE RESPONDENT THAT THIS SUBSECTION REQUIRES THAT SOME STATISTICS ARE GATHERED, IF SUCH INFORMATION IS NOT READILY AVAILABLE AT THE LOCATION WHERE THE INTERVIEW IS BEING CONDUCTED.

470	**CHECK Q110** INPATIENT CARE SERVICES AVAILABLE ☐	NO INPATIENT CARE SERVICES ☐	→ 472
471*	What was the total number of admissions (discharges) for the 2013 - 2014 fiscal year (July 2013 - June 2014), for all conditions, both adults and children?	# OF DISCHARGES ☐☐☐☐☐☐ DON'T KNOW. 999998	
471A*	What was the total number of inpatient days for the 2013 - 2014 fiscal year (July 2013 - June 2014), for all conditions, both adults and children?	# OF INPATIENT DAYS ☐☐☐☐☐☐ DON'T KNOW. 999998	
472*	What was the total number of outpatient client visits during the 2013 - 2014 fiscal year (July 2013 - June 2014) for both adults and children?	# OF CLIENT VISITS ☐☐☐☐☐☐ DON'T KNOW. 999998	
472E	Has this health facility displayed updated key health services data in the health facility premises in a visible place for the public?	YES. . . . . 1 NO. 2	→480A
472F	OBSERVE THE DISPLAYED MATERIALS.	RECORD OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

LMIS

480X	**CHECK Q006** FACILITY IS NOT A PRIVATE HOSPITAL NOR A HTC STAND ALONE (NEITHER "06" NOR "11"CIRCLED) ☐	FACILITY IS EITHER A PRIVATE HOSPITAL OR A HTC STAND ALONE (EITHER "06" OR "11" CIRCLED) ☐	→ NEXT SECTION

FIND THE PERSON RESPONSIBLE FOR HEALTH LOGISTICS MANAGEMENT INFORMATION SYSTEMS. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE ASSESSMENT BEFORE PROCEEDING WITH QUESTIONS IN THIS SUBSECTION.
NOTIFY THE RESPONDENT THAT THIS SUBSECTION REQUIRES TO SEE SOME REPORTS AND GUIDELINES IF SUCH INFORMATION IS NOT READILY AVAILABLE AT THE LOCATION WHERE THE INTERVIEW IS BEING CONDUCTED.

480A	Does this facility have a system in place to regularly manage health LMIS data?	YES. . . . . 1 NO. 2	
480B	Does this health facility regularly compile any reports containing health LMIS?	YES. . . . . 1 NO 2	→480D
480C	May I see a copy of this health facility's LMIS report for the last completed quarter ?	RECORD OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
480D	Does this facility have a designated person, who is responsible for health LMIS data in this facility?	YES. . . . . 1 NO. 2	→480H
480E	Who is responsible for health LMIS data in this facility? PROBE TO DETERMINE WHO THIS PERSON IS	LHMIS PERSON. . . . . 1 FACILITY IN-CHARGE. . . . . 2 OTHER SERVICE PROVIDER. 3	
480F	Is the designated person formally trained on logistics management?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	→480H
480G	When was the designated person formally trained on logistics management?	YEAR ☐☐☐☐ DON'T KNOW. 9998	
480H	Do you have the Storage and Reporting Guidelines for Health Logistics (FLEX) available in this health facility?	YES. . . . . 1 NO. 2	→480J
480I	May I see the Storage and Reporting Guidelines for Health Logistics (FLEX)?	RECORD OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
480J	Do you have the Health Logistics Pull System Manual available in this health facility?	YES. . . . . 1 NO. . . . . 2 NEXT SECTION	
480K	May I see the Health Logistics Pull System Manual?	RECORD OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

SECTION 5: PROCESSING OF INSTRUMENTS FOR REUSE

ASK TO BE SHOWN THE MAIN LOCATION WHERE SURGICAL INSTRUMENTS ARE PROCESSED/STERILIZED IN THE FACILITY FOR REUSE. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROCESSING OF SURGICAL INSTRUMENTS IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND PROCEED.

500 **CHECK Q201:** ARE ANY EQUIPMENT PROCESSED IN THE FACILITY?

YES (CODES 1 or 2 CIRCLED) ↓

NO (CODE 3 CIRCLED) → GO TO NEXT SECTION OR SERVICE SITE

501 ASK IF EACH OF THE INDICATED ITEMS BELOW IS USED BY THE FACILITY AND AVAILABLE. IF AVAILABLE, ASK TO SEE IT. ASK IF IT IS FUNCTIONING OR NOT
FOR EXAMPLE: "Do you use [METHOD] in facility?" IF YES, ASK: "May I see it?" THEN "Is it functioning?"

	ITEM	(A) USE AND AVAILABILITY: OBSERVED	(A) USE AND AVAILABILITY: REPORTED NOT SEEN	(A) USE AND AVAILABILITY: NOT USED	(B) FUNCTIONING: YES	(B) FUNCTIONING: NO	(B) FUNCTIONING: DON'T KNOW
01	ELECTRIC AUTOCLAVE (PRESSURE & WET HEAT)	1→ b	2→ b	3 ┐ 2 ┘	1	2	8
02*	NON-ELECTRIC AUTOCLAVE (PRESSURE & WET HEAT, GAS KEROSENE)	1→ b	2→ b	3 ┐ 3 ┘	1	2	8
03	ELECTRIC DRY HEAT STERILIZER	1→ b	2→ b	3 ┐ 4 ┘	1	2	8
04	ELECTRIC BOILER OR STEAMER (NO PRESSURE)	1→ b	2→ b	3 ┐ 5 ┘	1	2	8
05	NON-ELECTRIC POT WITH COVER FOR BOILING/STEAM	1→ b	2→ b	3 ┐ 6 ┘	1	2	8
06	HEAT SOURCE FOR NON-ELECTRIC EQUIPMENT (STOVE OR FIRE WOOD)	1→ b	2→ b	3 ┐ 7 ┘	1	2	8
07	AUTOMATIC TIMER (MAY BE ON EQUIPMENT)	1→ b	2→ b	3 ┐ 8 ┘	1	2	8
08*	TST INDICATOR STRIPS/OTHER ITEM THAT INDICATES PROCESS IS COMPLETE (AUTOCLAVE TAPE)	1	2	3			
09*	ANY CHEMICALS FOR CHEMICAL HLD (CIDEX)	1	2	3			

502* CHECK **Q501.** FOR EACH OF THE FOLLOWING METHODS OF STERILIZATION/HIGH LEVEL DISINFECTION THAT IS USED IN THE FACILITY, ASK YOUR RESPONDENT AND INDICATE THE PROCESSING DETAILS, INCLUDING PROCESSING TIME, RECOMMENDED PRESSURE, ETC.

		(1)* AUTOCLAVE (steam with pressure)	(2) DRY HEAT STERILIZATION	(3) BOILING (HLD)	(4) STEAM HIGH LEVEL DISINFECTION (HLD)	(5) CHEMICAL HIGH LEVEL DISINFECTION (HLD)
A	Method	USED . . . . . 1 NOT USED . . 2→ 2	USED . . . . . 1 NOT USED . . 2→ 3	USED . . . . . 1 NOT USED . . . . . 2→ 4	USED . . . . . 1 NOT USED . . 2→ 5	USED . . . . . 1 NOT USED . . 2→503
B	Temperature (centigrade)	TEMPERATURE ☐☐☐ AUTOMATIC . . . . 666 DON'T KNOW 998	TEMPERATURE ☐☐☐ AUTOMATIC . . . . 666 DON'T KNOW 998			
C	Pressure	PRESS-URE ☐☐☐ AUTOMATIC 666 DON'T KNOW 998→1E				
D	Units of pressure	UNITS OF PRESSURE: KG/SQ CM. . . . . 1 ATM PRESSURE. . . . . 2 KILOPASCAL . . . . . 3 MILLIMETER HG 4 LB/SQ IN. . . . . 5 DON'T KNOW. 8				
E*	What is the duration in minutes when **instrument is not wrapped in cloth** for [METHOD]?		MINUTES ☐☐☐ AUTOMATIC . . . . . 666 DON'T KNOW. 998	MINUTES ☐☐☐ DON'T KNOW. 998	MINUTES ☐☐☐ DON'T KNOW. 998	MINUTES ☐☐☐ DON'T KNOW. . . . 998
F*	What is the duration in minutes when **instrument is wrapped in single or double cloth** for autoclave?	MINUTES WRAPPED ☐☐☐ AUTOMATIC . . . . . 666 NOT USED. . . . . 995 DON'T KNOW 998				
G*	Chemical disinfectant used					ALCOHOL. . . . . A BETADINE . . . . . B CHLORINE. . . . . C CIDEX / GLUTERALDEHYDE. . D FORMALDEHYDE. . . . . E DON'T KNOW. . . . . Z

503*	In am interested in guidelines for sterilization. Does this facility have the National Medical Standard For Reproductive Health Volume I: Contraceptive Services at this site? HAND-WRITTEN GUIDELINES POSTED ON WALLS IN AREA WHERE EQUIPMENT IS PROCESSED OR STERILIZED IS ACCEPTABLE	YES. . . . . 1 NO 2	→ NEXT SECTION
504	May I see the National Medical Standard For Reproductive Health Volume I: Contraceptive Services? HAND-WRITTEN GUIDELINES POSTED ON WALLS IN AREA WHERE EQUIPMENT IS PROCESSED OR STERILIZED IS ACCEPTABLE	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	

SECTION 6: HEALTH CARE WASTE MANAGEMENT AND CLIENT LATRINE

FIND THE PERSON RESPONSIBLE FOR WASTE MANAGEMENT ACTIVITIES IN THE FACILITY. INTRODUCE YOURSELF AND EXPLAIN THE PURPOSE OF THE ASSESSMENT BEFORE PROCEEDING WITH THE QUESTIONS

600A	Do you segragate the waste at the time of collection ?	YES. . . . . 1 NO. 2	
600	Now I would like to ask you a few questions about waste management practices for sharps waste, such as needles or blades. How does this facility ***finally*** dispose of ***sharps waste*** (e.g., filled sharps boxes)? PROBE TO ARRIVE AT CORRECT RESPONSE **NOTE!** IF ANY OF THE RESPONSES **02 - 09** TAKE PLACE OUTSIDE THE FACILITY, THEN THE CORRECT RESPONSE TO CIRCLE WILL BE IN THE CATEGORY OF "REMOVE OFFSITE"	**BURN IN INCINERATOR:** 2-CHAMBER INDUSTRIAL (800-1000+°C). . . . . 02 1-CHAMBER DRUM/BRICK. . . . . 03 **OPEN BURNING** FLAT GROUND-NO PROTECTION. . . . . 04 PIT OR PROTECTED GROUND. . . . . 05 **DUMP WITHOUT BURNING** FLAT GROUND-NO PROTECTION. . . . . 06 COVERED PIT OR PIT LATRINE. . . . . 07 OPEN PIT-NO PROTECTION. . . . . 08 PROTECTED GROUND OR PIT. . . . . 09 **REMOVE OFFSITE** STORED IN COVERED CONTAINER. . . . . 10 STORED IN OTHER PROTECTED ENVIRONMENT. . . . . 11 STORED UNPROTECTED. . . . . 12 **BURN AND DUMP . . . . . 13** **OTHER**_____ 96 (SPECIFY) NEVER HAVE SHARPS WASTE 95	
601	Now I would like to ask you a few questions about waste management practices for medical waste other than sharps, such as used bandages How does this facility ***finally*** dispose of ***medical waste*** other than sharps boxes? PROBE TO ARRIVE AT CORRECT RESPONSE **NOTE!** IF ANY OF THE RESPONSES **02 - 09** TAKE PLACE OUTSIDE THE FACILITY, THEN THE CORRECT RESPONSE TO CIRCLE WILL BE IN THE CATEGORY OF "REMOVE OFFSITE"	SAME AS FOR SHARP ITEMS. . . . . 01 **BURN IN INCINERATOR:** 2-CHAMBER INDUSTRIAL (800-1000+°C). . . . . 02 1-CHAMBER DRUM/BRICK. . . . . 03 **OPEN BURNING** FLAT GROUND-NO PROTECTION. . . . . 04 PIT OR PROTECTED GROUND. . . . . 05 **DUMP WITHOUT BURNING** FLAT GROUND-NO PROTECTION. . . . . 06 COVERED PIT OR PIT LATRINE. . . . . 07 OPEN PIT-NO PROTECTION. . . . . 08 PROTECTED GROUND OR PIT. . . . . 09 **REMOVE OFFSITE** STORED IN COVERED CONTAINER. . . . . 10 STORED IN OTHER PROTECTED ENVIRONMENT. . . . . 11 STORED UNPROTECTED. . . . . 12 **BURN AND DUMP . . . . . 13** **OTHER** _____ 96 (SPECIFY) NEVER HAVE OTHER MEDICAL WASTE. 95	
601A	How does this facilty dispose of expired medicines?	RETURN TO IT SOURCE. . . . . 1 BURNING PIT. . . . . 2 INCINERATOR. . . . . 3 BURNING CHAMBER WITH CHIMNEY 4 DUMP. . . . . 5 REMOVE OFFSITE. 6	

602	**CHECK Q600** FACILITY-BASED WASTE DISPOSAL OR WASTE REMOVED OFFSITE (ANY CODE OTHER THAN "95" CIRCLED)	NEITHER FACILITY-BASED WASTE DISPOSAL NOR REMOVAL OFFSITE (CODE "95" CIRCLED) → 604	
603	ASK TO SEE THE PLACE USED BY THIS FACILITY FOR DISPOSAL OF SHARPS WASTE AND INDICATE THE CONDITION OBSERVED. IF SHARPS WASTE IS DISPOSED OFF-SITE, OBSERVE THE SITE WHERE IT IS STORED PRIOR TO COLLECTION FOR OFF-SITE DISPOSAL. IF SITE NOT INSPTECTED, CIRCLE '8'.	NO WASTE VISIBLE. . . . . 1 WASTE VISIBLE, BUT PROTECTED AREA. . . . . 2 WASTE VISIBLE, ***NOT*** PROTECTED. . . . . 3 WASTE SITE NOT INSPECTED. 8	
603A	**CHECK Q600** SHARPS WASTE REMOVED OFFSITE (CODE 10, 11 OR 12 CIRCLED)	FACILITY-BASED SHARPS WASTE DISPOSAL (ANY CODE OTHER THAN 10, 11, 12 OR "95" CIRCLED) → 604	
603B	Is sharps waste desinfected prior to collection for off-site disposal?	YES. . . . . 1 NO. 2	
604	**CHECK Q601** FACILITY-BASED WASTE DISPOSAL OR WASTE REMOVED OFFSITE (ANY CODE "02" TO "96" CIRCLED)	NEITHER FACILITY-BASED WASTE DISPOSAL NOR REMOVAL OFFSITE (CODE "01" OR "95" CIRCLED) → 606	
605	ASK TO SEE THE PLACE USED BY THIS FACILITY FOR DISPOSAL OF MEDICAL WASTE AND INDICATE THE CONDITION OBSERVED. IF MEDICAL WASTE IS DISPOSED OFF-SITE, OBSERVE THE SITE WHERE IT IS STORED PRIOR TO COLLECTION FOR OFF-SITE DISPOSAL. IF SITE NOT INSPTECTED, CIRCLE '8'.	NO WASTE VISIBLE. . . . . 1 WASTE VISIBLE, BUT PROTECTED AREA. . . . . 2 WASTE VISIBLE, ***NOT*** PROTECTED. . . . . 3 WASTE SITE NOT INSPECTED. 8	
605A	**CHECK Q601** MEDICAL WASTE REMOVED OFFSITE (CODE 10, 11 OR 12 CIRCLED)	FACILITY-BASED MEDICAL WASTE DISPOSAL (ANY CODE "02" TO "96" OTHER THAN 10, 11 OR 12 CIRCLED) → 606	
605B	IF MEDICAL WASTE IS DISPOSED OFF-SITE. ASK Is medical waste desinfected prior to collection for off-site disposal?	YES. . . . . 1 NO. 2	
606	**CHECK Q600 AND Q601** INCINERATOR USED (EITHER "2" OR "3" CIRCLED)	INCINERATOR NOT USED (NEITHER "2" NOR "3" CIRCLED) → 610	
607	ASK TO BE SHOWN THE INCINERATOR	INCINERATOR OBSERVED. . . . . 1 INCINERATOR REPORTED NOT SEEN. 2	
608	Is the incinerator functional today? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES 1 NO. . . . . 2 DON'T KNOW. . . . . 8 → 610	
609	Is fuel available today for the incinerator? ACCEPT REPORTED RESPONSE	YES . . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
610*	Do you have any guidelines on health care waste management available in this service area? This may be part of the infection prevention guideline or protocol, waste management guideline, LEAD guideline, syringe disposal guideline)	YES. . . . . 1 NO GUIDELINE AVAILABLE. . . . . 2 → 620	
611	May I see the guidelines on health care waste management?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	

CLIENT LATRINE

620	Is there a toilet (latrine) in ***functioning condition*** that is available for general outpatient client use? IF YES, ASK TO SEE THE CLIENT TOILET AND INDICATE THE TYPE. THIS MUST BE TOILET FACILITIES FOR THE MAIN OUTPATIENT SERVICE AREA.	**FLUSH OR POUR FLUSH TOILET** FLUSH TO PIPED SEWER SYSTEM. . . . . 11 FLUSH TO SEPTIC TANK . . . . . 12 FLUSH TO PIT LATRINE. . . . . 13 FLUSH TO SOMEWHERE ELSE. . . . . 14 FLUSH, DON'T KNOW WHERE. . . . . 15 **PIT LATRINE** VENTILATED IMPROVED PIT LATRINE. . . . . 21 PIT LATRINE WITH SLAB. . . . . 22 PIT LATRINE WITHOUT SLAB / OPEN PIT. . . . . 23 COMPOSTING TOILET . . . . . 31 BUCKET TOILET. . . . . 41 HANGING TOILET / HANGING LATRINE. . . . . 51 NO FUNCTIONING FACILITY / BUSH / FIELD. 61	
620A	CHECK IF THE TOILET (LATRINE) IS DISABLE-FRIENDLY. i.e. PROVIDING ENOUGH SPACE FOR WHEELCHAIR AND ELEVAT TOILET ITSELF FOR EASY MOUNTING FROM A WHEELCHAIR	YES. . . . . 01 NO. 02	

SECTION 7: BASIC SUPPLIES - CLIENT EXAMINATION ROOM CLIENT WAITING AREA

AT THIS POINT TELL YOUR RESPONDENT THAT YOU WOULD LIKE TO SEE SOME BASIC SUPPLIES AND EQUIPMENT USED IN THE PROVISION OF CLIENT SERVICES. YOU WOULD LIKE TO SEE IF THESE SUPPLIES AND EQUIPMENT ARE AVAILABLE IN THE GENERAL OUTPATIENT AREA. IF YOU ARE NOT IN THE GENERAL OUTPATIENT AREA, ASK TO BE TAKEN TO THE GENERAL OUTPATIENT AREA.

BASIC SUPPLIES AND EQUIPMENT

		(A) AVAILABLE			(B) FUNCTIONING		
700*	I would like to know if the following items are available today in the main service area and are functioning ASK TO SEE ITEMS.	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	ADULT WEIGHING SCALE	1 → b	2 → b	3	1	2	8
02	CHILD WEIGHING SCALE [250 GRAM GRADATION]	1 → b	2 → b	3	1	2	8
03	INFANT WEIGHING SCALE [100 GRAM GRADATION]	1 → b	2 → b	3	1	2	8
04	STADIOMETER (OR HEIGHT ROD) FOR MEASURING HEIGHT	1 → b	2 → b	3	1	2	8
05	MEASURING TAPE [FOR HEAD CIRCUMFERENCE]	1 → b	2 → b	3	1	2	8
06	THERMOMETER	1 → b	2 → b	3	1	2	8
07	STETHOSCOPE	1 → b	2 → b	3	1	2	8
08	DIGITAL BP APPARATUS	1 → b	2 → b	3	1	2	8
09	MANUAL BP APPARATUS	1 → b	2 → b	3	1	2	8
10	LIGHT SOURCE (FLASHLIGHT ACCEPTABLE)	1 → b	2 → b	3	1	2	8
11	SELF-INFLATING BAG AND MASK [ADULT]	1 → b	2 → b	3	1	2	8
12	SELF-INFLATING BAG AND MASK [PEDIATRIC]	1 → b	2 → b	3	1	2	8
13*	NEBULIZER	1 → b	2 → b	3	1	2	8
14	SPACERS FOR INHALERS	1	2	3			
15*	OXYGEN FLOW METERS	1 → b	2 → b	3	1	2	8
16	PULSE OXIMETER	1 → b	2 → b	3	1	2	8
17	OXYGEN CONCENTRATORS	1 → b	2 → b	3	1	2	8
18	FILLED OXYGEN CYLINDER	1 → b	2 → b	3	1	2	8
19	OXYGEN DISTRIBUTION SYSTEM	1 → b	2 → b	3	1	2	8
20	INTRAVENOUS INFUSION KITS - ADULT	1	2	3			
21	INTRAVENOUS INFUSION KITS - PEDIATRIC	1	2	3			
22*	WHEEL CHAIR	1 → b	2 → b	3	1	2	8

700C	Was an equipment audit conducted for this facility during the 2013-2014 fiscal year?	YES. . . . . 1 NO . . . . . 2 DON'T KNOW. 8	 →710 →710
700D	May I see the audit report for 2013-2014 fiscal year?	OBSERVED. . . . . 1 REPORTED, NOT SEEN 2	

CLIENT EXAMINATION ROOM

AT THIS POINT ASK TO BE SHOWN THE ROOM OR AREA IN THE GENERAL OUTPATIENT AREA WHERE MOST CLIENT SERVICES ARE OFFERED. OBSERVE THE CONDITION UNDER WHICH MOST CLIENT EXAMINATION TAKE PLACE. INDICATE IF THE FOLLOWING ITEMS ARE AVAILABLE IN THE ROOM OR AREA. ASK TO BE SHOWN ITEMS THAT YOU DO NOT SEE.

710*	**INFECTION CONTROL AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND COLOR CODED PLASTIC BIN LINER / LABELED BIN (RED, GREEN, YELLOW AND BLUE)	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT/ANTISEPTICS [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE-USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR AUTO-DISABLE SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13	INJECTION SAFETY PRECAUTION GUIDELINES FOR STANDARD PRECAUTIONS (Surakchhit sui ko niti)	1	2	3
14*	NEEDLE DESTROYER	1	2	3
15*	METHYLATED SPIRIT AND GLYCIRINE 70:30	1	2	3
711	DESCRIBE THE SETTING OF THE ROOM OR SERVICE AREA	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4		

CLIENT WAITING AREA

720	Is there a waiting area for clients where they ***are protected from the sun and rain?*** ASK TO SEE THE CLIENT WAITING AREA. MUST BE THE WAITINGAREA IN THE MAIN OUTPATIENT SERVICE AREA.	YES. . . . . 1 NO PROTECTED CLIENT WAITING AREA 2	

DISASTER PREPAREDNESS

720A*	Does this facility have a disaster preparedness contingency plan/manual?	YES. . . . . 1 NO. 2	→ 720C
720B*	May I see the disaster preparedness contingency plan/manual	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
720C*	Does this facility conducted "Drill down" exercises as part of disaster prepareness training?	YES. . . . . 1 NO . . . . . 2 DON'T KNOW 8	

SECTION 8: DIAGNOSTICS

800	**CHECK Q102.17** DIAGNOSTIC SERVICES AVAILABLE IN FACILITY ☐ → NO DIAGNOSTIC SERVICES ☐ → GO TO NEXT SECTION OR SERVICE SITE	

ASK TO BE SHOWN THE MAIN LABORATORY OR LOCATION IN THE FACILITY WHERE MOST TESTING IS DONE TO START DATA COLLECTION. INTRODUCE YOURSELF AND EXPLAIN THE PURPOSE OF THE SURVEY. FOR EACH OF THE TEST OF INTEREST, ASK AND GO TO THE MAIN LOCATION IN THE FACILITY WHERE THE INFORMATION WILL BE AVAILABLE. IF INFORMATION IS NOT IN THAT LOCATION ASK IF IT IS ANYWHERE ELSE IN THE FACILITY AND GO THERE TO COMPLETE THE QUESTIONNAIRE.

HEMATOLOGY

801*	Does this facility do any hemoglobin testing on site, i.e. in the facility?					YES . . . . . 1 NO . . . . . 2 → 802D				
802*	Please tell me if: **a)** Any of the following hemoglobin test equipment is used in this facility, **b)** All items needed for the test are available, and **c)** Equipment is in working order	**(a) USED**		**(b) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**			**(c) IS THE ITEM IN WORKING ORDER/UNEXPIRED**			
		Yes	No	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW	
01	Hematology analyzer (for total lymphocyte count, full blood count, platelet count, etc.)	1 → b	2 → 02	1 → c	2 → c	3 → 02	1 → 802D	2	8	
02	HemoCue	1 → b	2 → 04	1 → c	2 → c	3 → 04	1	2	8	
03	Microcuvette			1 → c	2 → c	3 → 04	1	2	8	
04*	Colorimeter or hemoglobinometer	1 → b	2 → 08	1 → c	2 → c	3 → 08	1	2	8	
05	Drabkin's or other country-specific solution (for colorimeter and hemoglobinometer)			1	2	3				
06*	Pipette (for measuring blood volume)	1 → b	2 → 08	1	2	3				
08*	Sahli's hemoglobinometer	1 → b	2 → 09	1	2	3				
09	Other _____ (SPECIFY)	1 → b	2 → 802D	1	2	3				
802D	Does this facility do any test for complete blood count (CBC) on site, i.e. in the facility, using hemocytometer?					YES . . . . . 1 NO . . . . . 2 → 803				
802E	Please tell me if the following items needed for the test are available and in working order			**(b) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**			**(c) IS THE ITEM IN WORKING ORDER?**			
				OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW	
01	Hemocytometer (Glass slide)			1 → c	2 → c	3 → 02	1	2	8	
02	Cover glass for Hemocytometer			1 → c	2 → c	3 → 03				
03	Microscope for hemocytometer			1 → c	2 → c	3 → 803	1	2	8	
803*	Is CD4 testing services available from this facility?					YES. . . . . 1 NO. . . . . 2 → 806				
803A	What type of CD4 testing service is available at this facility?					MOBILE . . . . . 1 STATIC . . . . . 2 → 806				

		(a)		(b)			(c)		
804*	Please tell me if (Static service): **a)** Any of the following CD4 test equipment or assay is used in this facility, **b)** Equipment or items needed for the test are available, and **c)** Equipment is in working order	**USED**		**EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**			**IS THE ITEM IN WORKING ORDER OR UNEXPIRED?**		
		Yes	No	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	Flow cytometer analyzer (e.g., FACS count machine (BD or PATEK Brand))	1 → b	2 → 03	1 → c	2 → c	3 → 03	1	2	8
02	Reagent kits for BD or Partek analyzer			1	2	3			
03	Flow cytometer analyzer - PIMA Brand	1 → b	2 → 05	1 → c	2 → c	3 → 05	1	2	8
04	Cartridges for PIMA analyzer			1	2	3			
05	Rapid CD4 test strips	1 → b	2 → 806	1 → c	2 → c	3 → 806	1	2	8

HIV TESTING

806	Does this facility conduct any HIV tests?, including HIV RDT, either in the facility or through referral?	YES. . . . . 1 NO. 2					→ 827
807	Is HIV rapid diagnostic testing available from this service site?	YES. . . . . 1 NO. 2					→ 809
808*	Please tell me if any of the following HIV rapid diagnostic test (RDT) kits are available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED			
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NO, NEVER AVAILABLE	
01	DETERMINE	1	2	3	4	5	
02	UNIGOLD	1	2	3	4	5	
03	STATPACK	1	2	3	4	5	
04	TRIDOT	1	2	3	4	5	
05	OTHER (SPECIFY) _____	1	2	3	4	5	
809*	Do you use DBS card/paper to collect dried blood spots (DBS) at this site ?	YES. . . . . 1 NO. 2					→ 811
809A	For what purpose are DBS samples collected?	EXTERNAL QUALITY ASSURANCE (EQUAS). . . . . 1 EARLY INFANT DIAGNOSIS (EID). . . . . 2 BOTH. . . . . 3 DON'T KNOW. 8					
810*	May I see a sample DBS paper/ card? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4					

811*	Please tell me if: **a)** Any of the following HIV test or test equipment is used in this facility, **b)** All items needed for the test are available, and **c)** Equipment is in working order or kit unexpired	**(a)** **EQUIPMENT USED/ TEST CONDUCTED**		**(b)** **ARE ALL ITEMS FOR TEST AVAILABLE?**			**(c)** **IS THE ITEM IN WORKING ORDER OR UNEXPIRED?**		
		Yes	No	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01*	HIV testing using ELISA assay/ CLIA	1	2 → 06						
02	ELISA/CLIA scanner or reader	1 → b	2 → 06	1 → c	2 → c	3 → 03	1	2	8
03	Plate Washer [ACCEPTABLE IF MANUAL WASHING]			1 → c	2 → c	3 → 04	1	2	8
04*	Specific ELISA assay / CLIA kit. E.G., BIO KIT ENZYGNOST, VIRONOSTICA, MUREX			1 → c	2 → c	3 → 05	1	2	8
05	INCUBATOR	1 → b	2 → 06	1 → c	2 → c	3 → 06	1	2	8
06*	Vortex mixer	1 → b	2 → 07	1 → c	2 → c	3 → 07	1	2	8
07	Western Blot test (assay)	1 → b	2 → 08	1	2	3			
08	PCR for viral load	1 → b	2 → 09	1 → c	2 → c	3 → 09	1	2	8
09	PCR for DNA-EID	1 → b	2 → 812	1 → c	2 → c	3 → 812	1	2	8

812*	Do you have the national HIV testing -guidelines on how to conduct HIV test (SOP, etc.)	YES. . . . . 1 NO. 2	→ 814
813	May I see the guidelines, instructions or SOP?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	
814*	Do you have the national HIV testing guidelines on confidentiality and disclosure of HIV test results MAY BE PART OF ANOTHER GUIDELINE	YES. . . . . 1 NO. 2	→ 816
815*	May I see the national HIV testing guidelines on confidentiality and disclosure of HIV results?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	
816*	Do you have the HIV testing guidelines ?	YES. . . . . 1 NO. 2	→ 818
817*	May I see the HIV testing guidelines?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	

818	Is there an established system for external quality control for the HIV tests conducted by this laboratory?	YES. . . . . 1 NO. 2	→823
819*	What system of external quality control for HIV tests is used in this laboratory ? PROBE FOR SYSTEM USED. CIRCLE ALL THAT APPLY	PROFICIENCY PANEL. . . . . A EXTERNAL INSPECTION/ OBSERVATION OF TECHNIQUE. . . . . B BLOOD SENT OUTSIDE/CENTRAL LABORAT(C OTHER_____ X	
820	Is there a record of the results from the external quality check?	YES. . . . . 1 NO. 2	→823
821	May I see the records or results from the external quality check?	OBSERVED . . . . . 1 REPORTED, NOT SEEN. 2	→823
822	WHAT IS THE MOST RECENT ERROR RATE RECORDED BY THE EXTERNAL QUALITY CONTROL, ACCORDING TO THE REGISTER	PERCENT ERROR RATE . . . . . ☐☐ NOT AVAILABLE.. 95	
823*	Do you send blood outside the facility for HIV diagnostic testing?	YES. . . . . 1 NO. 2	→827
824*	For which HIV test do you send blood outside? PROBE	ELISA/EIA / CLIA. . . . . A WESTERN BLOT. . . . . B PCR FOR EID. . . . . C RAPID TESTING. . . . . D OTHER. X	
825	Do you maintain records of test result of HIV tests that are conducted outside of this facility?	YES. . . . . 1 NO. 2	→827
826	May I see records of recent tests conducted outside this facility?	OBSERVED . . . . . 1 REPORTED, NOT SEEN. 2	

INFECTION CONTROL

ASSESS THE HIV TESTING AREA (OR GENERAL LAB AREA IF NO HIV TESTING) FOR THE FOLLOWING ITEMS.
FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU.

827*	**INFECTION CONTROL AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04*	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND COLOR CODED PLASTIC BIN LINER / LABELED BIN (RED, GREEN, YELLOW AND BLUE)	1 ┐ 06◄	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE-USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR AUTO-DISABLE SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13	INJECTION SAFETY PRECAUTION GUIDELINES FOR STANDARD PRECAUTIONS (Surakchhit sui ko niti)	1	2	3
14*	NEEDLE DESTROYER	1	2	3
15*	METHYLATED SPIRIT AND GLYCIRINE 70:30	1	2	3

CLINICAL CHEMISTRY

830	Does this facility do any blood glucose testing in the facility?	YES . . . . . 1 NO . . . . . 2 → 832								
831	Please tell me if: **a)** Any of the following blood glucose test equipment is used in this facility **b)** Equipment is available, and **c)** Equipment is in working order	**(a) USED**		**(b) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**			**(c) IS THE ITEM IN WORKING ORDER OR UNEXPIRED?**			
		Yes	No	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW	
01	Glucometer	1 → b	2 → 832	1 → c	2 → c	3 → 832	1	2	8	
02	Glucometer test strips			1 → c	2 → c	3 → 832	1	2	8	
832*	Does this facility do any ***liver function tests*** (such as ALT & AST) or ***renal function tests*** (such as serum creatinine, urea) on site?	YES. . . . . 1 NO. . . . . 2 → 835A								
833*	Does this facility have a blood chemistry analyzer that provides serum creatinine, LFTs and glucose?	YES. . . . . 1 NO. . . . . 2 → 835A								
834	May I see the blood chemistry analyzer?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2								
835	Is the blood chemistry analyzer functioning? ACCEPT REPORTED RESPONSE	YES. . . . . 1 NO. 2								
835A	Does this facililty do bilirubin test?	YES. . . . . 1 NO. . . . . 2 → 836								
835B	Does this facililty have Bilirubinometer/Colorimeter that provides serum bilirubin?	YES. . . . . 1 NO. . . . . 2 → 836								
835C	May I see the Bilirubinometer/Colorimeter?	OBSERVED. . . . . 1 REPORTED NOT SEEN. . . . . 2 NOT AVAILABLE TODAY. . . . . 3 → 836								
835D	Is the Bilirubinometer/Colorimeter is working order?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8								
836	Does this facility do any ***urine chemistry testing*** using dipsticks and/or ***urine pregnancy test*** on site?	YES. . . . . 1 NO. . . . . 2 → 838								
837	Please tell me if any of the following dipstick test is done (or used) in this location. If done or used, I will like to see one. IF DONE/USED ASK TO SEE IT AND NOTE IF VALID/UNEXPIRED	**(A) USED**		**(B) OBSERVED AVAILABLE**						
		Yes	No	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED NOT SEEN	NORMALLY AVAILABLE NOT TODAY			
01	Dip sticks for urine protein	1 → b	2 → 02	1	2	3	4			
02	Dip sticks for urine glucose	1 → b	2 → 03	1	2	3	4			
03	Urine pregnancy test	1 → b	2 → 838	1	2	3	4			
838*	Do you ever send ***blood or urine*** outside the facility for blood chemistry, LFTs, urinalysis or pregnancy tests?	YES. . . . . 1 NO. . . . . 2 → 840X								
839*	INDICATE IF THERE IS AN OBSERVED RECORD OF RESULTS FOR TESTS CONDUCTED OUTSIDE	(A) SEND SPECIMEN OUTSIDE FOR TEST		(B) RECORD OF TEST RESULTS OBSERVED						
		YES	NO	YES	NO					
01*	Blood chemistry (e.g. glucose, sodium, potassium etc.)	1 → b	2 → 02	1	2					
02	Liver Function Test (LFT)	1 → b	2 → 03	1	2					
03	Urinalysis	1 → b	2 → 04	1	2					
04	Pregnancy test	1 → b	2 → 840	1	2					

PARASITOLOGY/BACTERIOLOGY

840X	Does this facility have any of the following equipment/test on site: light or electron microscope, refrigerator in lab, incubator, test tubes, centrifuge, culture medium, glass slides and	YES. . . . . 1 NO. 2	→841

840*	Please tell me if: **a)** Any of the following **EQUIPMENT** is used in the facility **b)** Is available, and **c)** Equipment is functioning	(a) **EQUIPMENT/ TEST USED**		(b) **EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**			(c) **IS THE ITEM IN WORKING ORDER?**		
		Yes	No	OBSERVED	REPORTED NOT SEEN	NORMALLY AVAILABLE NOT TODAY	YES	NO	DON'T KNOW
01	LIGHT MICROSCOPE	1→b	2 → 02	1→c	2→c	3 → 02	1	2	8
02	ELECTRON MICROSCOPE	1→b	2 → 03	1→c	2→c	3 → 03	1	2	8
03	REFRIGERATOR IN LAB AREA	1→b	2 → 04	1→c	2→c	3 → 04	1	2	8
04	INCUBATOR	1→b	2 → 05	1→c	2→c	3 → 05	1	2	8
05	TEST TUBES	1→b	2 → 06	1	2	3			
06*	CENTRIFUGE	1→b	2 → 07	1→c	2→c	3 → 7	1	2	8
07	CULTURE MEDIUM	1→b	2 → 08	1	2	3			
08	GLASS SLIDES AND COVERS	1→b	2 → 841	1	2	3			

841	Does this facility do any **MALARIA** tests (microscopy or mRDT) on site, i.e., in the facility?	YES. . . . . 1 NO. 2	→847C
842	Do you use malaria rapid diagnostic test to diagnose malaria at this laboratory/service site?	YES. . . . . 1 NO. 2	→847
843	May I see a sample malaria rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	
845	Do you have a training manual, poster or other job aid for using malaria rapid diagnostic test?	YES . . . . . 1 NO 2	→847
846	May I see the training manual, poster or other job aid for using malaria rapid diagnostic test?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

847*	Please tell me if: **a)** Any of the following malaria tests or equipment is used in the facility **b)** All items needed for the test are available	(a) EQUIPMENT/ TEST USED		(b) **EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**		
		Yes	No	OBSERVED	REPORTED NOT SEEN	NORMALLY AVAILABLE NOT TODAY
01*	GIEMSA STAIN / WRIGHT'S STAIN	1→b	2 → 02	1	2	3
02	FIELD STAIN	1→b	2 → 03	1	2	3
03	ACRIDINE ORANGE (AO microscope, and Acridine orange stain)	1→b	2 → 847C	1	2	3

847C*	Does this facility do any test for Diagnosis of Kalaazar / Leishmaniasis?	YES. . . . . 1 NO. 2	→ 848
847D*	Does this facility use rapid diagnostic test Kit (RK-39) for diagnosis of Kalaazar / Leishmaniasis??	YES. . . . . 1 NO. 2	→ 848
847E	May I see a sample of RK-39? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY 4	
848	Does this facility do any **GRAM STAINING?**	YES. . . . . 1 NO. 2	→ 850

		(a)		(b)		
849	Please tell me if the following are used and are available today.	**USED**		**EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**		
	IF USED ASK TO SEE IT	Yes	No	OBSERVED	REPORTED, NOT SEEN	NORMALLY AVAILABLE NOT TODAY
01	Crystal violet or Gentian violet	1 → b	2 → 02	1	2	3
02	Lugol's iodine / Lugol's solution	1 → b	2 → 03	1	2	3
03	Acetone or Acetone alcohol	1 → b	2 → 04	1	2	3
04	Neutral red, carbol fuchsin, or other counter stain	1 → b	2 → 850	1	2	3

850	Do you ever send any specimen outside for ***Gram staining*** , ***India Ink staining, malaria testing*** or for culture?	YES. . . . . 1 NO. 2	→ 852

		(A) SEND SPECIMEN OUTSIDE FOR TEST		(B) RECORD OF TEST RESULTS OBSERVED	
851	INDICATE IF THERE IS AN OBSERVED RECORD OF RESULTS FOR TESTS CONDUCTED OUTSIDE	YES	NO	YES	NO
01	Gram stain	1 → b	2 → 02	1	2
02	India ink stain	1 → b	2 → 03	1	2
03	Malaria	1 → b	2 → 04	1	2
04	Specimen for culture	1 → b	2 → 852	1	2

852	Does this facility do **STOOL MICROSCOPY?**	YES. . . . . 1 NO. 2	→ 854

		(a)		(b)		
853	Please tell me if the following are used and are available today.	**USED**		**EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**		
		Yes	No	OBSERVED	REPORTED, NOT SEEN	NORMALLY AVAILABLE NOT TODAY
01	Formal saline (for concentration method)	1 → b	2 → 02	1	2	3
02	Normal saline (for direct microscopy)	1 → b	2 → 03	1	2	3
03	Lugol's iodine / Lugol's solution	1 → b	2 → 854	1	2	3

SYPHILIS

854	Does this facility do any **syphilis** testing on site, i.e., in the facility?	YES. . . . . 1 NO. 2	→ 859
855	Do you use syphilis rapid diagnostic test to diagnose syphilis at this service site?	YES. . . . . 1 NO. 2	→ 857
856	May I see a sample syphilis rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	
857	Other than syphilis RDT, does this facility conduct any other syphilis testing in the facility?	YES. . . . . 1 NO. 2	→ 859

	Please tell me if: **a)** Any of the following syphilis test or test equipment is used in this facility, **b)** All items needed for the test are available, and **c)** Equipment is in working order	**(a) TEST CONDUCTED**		**(b) ARE ALL ITEMS FOR TEST AVAILABLE?**			**(c) IS THE ITEM IN WORKING ORDER?**		
858		Yes	No	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	VDRL	1 → b	2 → 02	1	2	3			
02	PCR for STIs (CTN)	1 → b	2 → 03	1	2	3			
03	Rotator or shaker			1 → c	2 → c	3 → 04	1	2	3
04	Rapid plasma reagin test (RPR)	1 → b	2 → 05	1	2	3 → 05			
05	Treponema Pallidum Hemaglutination Assay (TPHA)	1 → b	2 → 859	1	2	3 → 859			

CHLAMYDIA

859	Does this facility do any **chlamydia** testing on site, i.e., in the facility?	YES. . . . . 1 NO 2	→ 861

	Please tell me if: **a)** Any of the following chlamydia test, test equipment, or stain is used in the facility; **b)** All items needed for the test are available, and	**(a) TEST CONDUCTED**		**(b) ARE ALL ITEMS FOR TEST AVAILABLE?**		
860*		Yes	No	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE
01*	Geimsa stain / Gram stain / Wright's stain	1 → b	2 → 02	1	2	3
02*	PCR for CHLAMYDIA	1 → b	2 → 861	1	2	3

TUBERCULOSIS

861	Does this facility do any **TB** tests on site**?**			YES. . . . . 1 NO. . . . . 2 → 865							
862	Please tell me IF: **a)** Any of the following TB tests or equipment is used in the facility **b)** All items needed for the test are available **c)** Equipment is functioning	(a) EQUIPMENT/ TEST USED		(b) **EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**			(c) **IS THE ITEM IN WORKING ORDER?**				
		Yes	No	OBSERVED	REPORTED NOT SEEN	NORMALLY AVAILABLE NOT TODAY	YES	NO	DON'T KNOW		
01	Ziehl-Neelson test for AFB	1	2 → 05								
02	Carbol-Fuchsin	1 → b	2 → 03	1	2	3					
03	Sulphuric Acid (20 - 25% concentration) or Acid Alcohol	1 → b	2 → 04	1	2	3					
04	Methylene Blue	1 → b	2 → 05	1	2	3					
05	Fluorescence Microscope (FM) - LED	1 → b	2 → 06	1 → c	2 → c	3 → 06	1	2	8		
06	Culture / growth medium for Mycobacterium Tuberculosis (e.g., MGIT 960)	1 → b	2 → 07	1	2	3					
07	Biosafety hood / cabinet	1 → b	2 → 08	1	2	3					
08	Auramine stain for Fluorescence Microscope ASK ONLY IF (05) YES AND AVAILABE (OBSERVED OR REPORTED NOT SEEN)	1 → b	2 → 863	1	2	3					
863*	Is Gene Expert services available at this facility?			YES. . . . . 1 NO. . . . . 2 → 865							
863A	What type of service is it?			MOBILE . . . . . 1 STATIC 2							
864*	May I see a sample TB rapid diagnostic test (RDT) kit for Gene Expert? CHECK TO SEE IF AT LEAST ONE IS VALID			OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY 4							
865	Do you maintain any sputum containers at this service site for collecting sputum specimen?			YES. . . . . 1 NO. . . . . 2 → 867							
866*	May I see a sample sputum container?			OBSERVED . . . . . 1 REPORTED, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY 4							
867	Does this laboratory send sputum outside the facility for TB testing?			YES. . . . . 1 NO . . . . . 2 DON'T KNOW. . . . . 8 → 870							
868	Do you maintain records of result of sputum tests conducted elsewhere?			YES. . . . . 1 NO. . . . . 2 → 870							
869	May I see the record or register?			OBSERVED . . . . . 1 REPORTED, NOT SEEN. 2							
869A	**CHECK Q861** TB TEST DONE ON SITE (CODE 1 CIRCLE) ☐			TB TEST NOT DONE ON SITE (CODE 2 CIRCLE) ☐ → 873A							
870*	Is there a system for quality control (either internal or external) for the TB sputum smears assessed in this laboratory?			YES. . . . . 1 NO . . . . . 2 → 873A							
871	Please tell me which type of Quality Control / Quality Assurance practice is followed by this facility PROBE TO DETERMINE WHICH TYPE OF QUALTY CONTROL IS USED			INTERNAL QC / QA ONLY. . . . . 1 EXTERNAL QC / QA ONLY. . . . . 2 INTERNAL & EXTERNAL QC / QA. . . . . 3 SEND SLIDE FOR RE-READING. . . . . 4 OTHER (SPECIFY)_____ 6							
872*	Are records maintained of the results from the quality control (internal or external) procedures?			YES. . . . . 1 NO. . . . . 2 → 873A							

873	Are records maintained for the internal QC / QA procedures, the external QC / QA procedures, or for both internal and external QC / QA procedures?	RECORDS FOR IQC / IQA ONLY. . . . . 1 RECORDS FOR EQC / EQA ONLY. . . . . 2 RECORDS FOR BOTH INTERNAL AND EXTERNAL QC / QA PROCEDURES. 3	
873A	Do you have the Sputum Microcopy Manual available in this service area?	YES. . . . . 1 NO. 2	→874A
873B	May I see the Sputum Microcopy Manual?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

HEPATITIS B & C

874A	Does this facility do any tests for Hepatitis B**?**	YES. . . . . 1 NO. 2	→874D
874B	Do you use Hep B RDT for detection of Hep B surface antigen (HBsAg)?	YES. . . . . 1 NO. 2	→874D
874C	May I see the kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY 4	
874D	Does this facility do any tests for Hepatitis C**?**	YES. . . . . 1 NO. 2	→880
874E	Do you use test kit to diagnose Hep C?	YES. . . . . 1 NO. 2	→880
874F	May I see the kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY 4	

DIAGNOSTIC IMAGING

880*	Does this facility perform diagnostic X-rays, ultrasound, computerized tomography or MRI? IF YES, ASK TO GO TO WHERE THE EQUIPMENT IS LOCATED AND SPEAK WITH THE MOST KNOWLEDGEABLE PERSON.	YES. . . . . 1 NO . . . . . 2 **SKIP TO NEXT SECTION**	

	Please tell me if: **a)** If any of the following imaging equipment is used in the facility **b**) if it is available today, and **c)** if it is functioning today	(a) EQUIPMENT USED		(b) EQUIPMENT AVAILABLE?			(c) IS THE ITEM IN WORKING ORDER?		
		Yes	No	OBSERVED	REPORTED NOT SEEN	NORMALLY AVAILABLE NOT TODAY	YES	NO	DON'T KNOW
01	DIGITAL X-RAY MACHINE NOT REQUIRING FILM	1→b	2 02	1→c	2→c	3 02	1	2	8
02	X-RAY MACHINE	1→b	2 04	1→c	2→c	3 03	1	2	8
03*	UNEXPOSED FILM FOR X-RAY			1→c	2→c	3 04	1	2	8
04*	ULTRASOUND MACHINE	1→b	2 05	1→c	2→c	3 05	1	2	8
05*	CT SCAN	1→b	2 06	1→c	2→c	3 06	1	2	8
06*	MRI	1→b	2 **NEXT SECTION**	1→c	2→c	3 **SKIP TO NEXT SECTION**	1	2	8 **ALL SKIP TO NEXT SECTION**

THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE

SECTION 9: MEDICINES AND COMMODITIES

900	**CHECK Q210**	FACILITY STORES MEDICINES ☐	FACILITY STORES NO MEDICINES ☐ → GO TO NEXT SECTION

SECTION 9.1: GENERAL MEDICINES AND SUPPLY ITEMS

ASK TO BE SHOWN THE MAIN LOCATION IN THE FACILITY WHERE MEDICINES AND OTHER SUPPLIES ARE STORED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT STORAGE AND MANAGEMENT OF MEDICINES AND SUPPLIES. IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS

I would like to know if the following medicines are available today in this facility. If any of the medicines I mention is stored in another location in the facility, please tell me where in the facility it is stored so I can go there to verify.

ANTIBIOTICS

		(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
901*	Are any of the following ***antibiotics*** available in this facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE
01	AMOXICILLIN TABLET/CAPSULE (Bacterial infections in adults) #	1	2	3	4	5
02	AMOXICILLIN SYRUP/SUSPENSION OR DISPERSIBLE PEDIATRIC-DOSED TABLETS (Oral antibiotics for children) #	1	2	3	4	5
03	AMOXICILIN/CLAVULINATE (AUGMENTIN) TABS (broad spectrum antibiotics)	1	2	3	4	5
04	AMPICILLIN (POWDER) INJECTION (Broad spectrum antibiotic)	1	2	3	4	5
05	AZITHROMYCIN TABS/CAPS (antibiotic) #	1	2	3	4	5
06	AZITHROMYCIN SYR/SUSPENSION (antibiotic)	1	2	3	4	5
08	CEFIXIME TABS/CAPS (antibiotic)	1	2	3	4	5
09	CEFTRIAXONE INJECTION (Injectable antibiotic) #	1	2	3	4	5
11	CO-TRIMOXAZOLE (TABS) (Oral antibiotics-adult formation) #	1	2	3	4	5
12	CO-TRIMOXAZOLE SUSPENSION OR DISPERSIBLE PEDIATRIC-DOSED TABLET (Oral antibiotics for children) #	1	2	3	4	5
13	DOXYCYCLINE TABS/CAPS [Broad spectrum antibiotic] #	1	2	3	4	5
14	ERYTHROMYCIN [Broad spectrum antibiotic, oral tabs]	1	2	3	4	5
15	ERYTHROMYCIN [oral suspension]	1	2	3	4	5
16	GENTAMYCIN INJECTION (Broad spectrum injectable antibiotic) #	1	2	3	4	5
17*	METRONIDAZOLE TABLETS/SYRUP [antibiotic/amebecide/antiprotozoal] #	1	2	3	4	5
18*	METRONIDAZOLE INJECTION/INFUSION #	1	2	3	4	5
19	PENICILLIN INJECTION (Broad spectrum injectable antibiotic)	1	2	3	4	5
20	TETRACYCLINE [Broad spectrum antibiotic, oral caps] #	1	2	3	4	5
21	TETRACYCLINE EYE OINTMENT	1	2	3	4	5
23*	CHLORAMPHENICOL (Caps/Applicap) #	1	2	3	4	5
24*	CLOXACILLIN (Tabs/Caps) #	1	2	3	4	5
25*	NEOMYCIN OINTMENT #	1	2	3	4	5
26*	CIPROFLOXACIN INFUSION	1	2	3	4	5
27*	CIPROFLOXACIN EAR DROP	1	2	3	4	5
28*	CIPROFLOXACIN EYE DROP	1	2	3	4	5

MEDICINES FOR WORM INFESTATION

902	Are any of the following medicines for the treatment of **worm infestations** available in the facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE
01	ALBENDAZOLE #	1	2	3	4	5
02	MEBENDAZOLE	1	2	3	4	5

MEDICINES FOR NON-COMMUNICABLE DISEASES

903	Are any of the following medicines for the management of **non-communicable diseases** available in the facility/location today?	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
	CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE
01	AMITRIPTYLINE (Depression) #	1	2	3	4	5
02	AMLODIPINE / NIFEDIPINE TABLETS (CCB for high blood pressure) #	1	2	3	4	5
03	ATENOLOL (Beta-blocker, Angina/hypertension) #	1	2	3	4	5
04	BECLOMETHASONE INHALER	1	2	3	4	5
05	BETAMETHASONE INJECTION	1	2	3	4	5
06	CAPTOPRIL / ENALAPRIL / ANY OTHER ACE INHIBITOR (Vaso-dilatation, cardiac hypertension) (ACE INHIBITOR)	1	2	3	4	5
07	DEXAMETHASONE INJECTION #	1	2	3	4	5
08	DIAZEPAM INJECTION (Anxiety/muscle relaxant/anticonvulsant) #	1	2	3	4	5
11*	EPINEPHRINE/ADRENALINE INJECTION #	1	2	3	4	5
12*	FUROSEMIDE / LASIX (DIURETIC) INJECTION/TABLETS #	1	2	3	4	5
13*	THIAZIDE DIURETIC (HYDROCHLOROTHIAZIDE) #	1	2	3	4	5
14	GLIBENCLAMIDE (Oral treatment for type-2 diabetes)	1	2	3	4	5
15*	GLUCOSE (5% DEXTROSE) INJECTABLE SOLUTION #	1	2	3	4	5
16	HEPARIN INJECTION	1	2	3	4	5
17	HYDROCORTISONE #	1	2	3	4	5
18	INSULIN INJECTIONS [DIABETES]	1	2	3	4	5
19	ISOSORBIDE DINITRATE	1	2	3	4	5
20	METFORMIN TABLETS #	1	2	3	4	5
22*	RANITIDINE / OMEPRAZOLE / PENTOPRAZOLE (Gastro-esophageal reflux) #	1	2	3	4	5
23	PREDNISOLONE #	1	2	3	4	5
24*	SALBUTAMOL TABLETS/INHALER (Bronchospasms/Chronic asthma) #	1	2	3	4	5
25	SIMVASTATIN (High cholesterol)	1	2	3	4	5
26	ASPIRIN CAPSULES/TABLETS #	1	2	3	4	5
27	METOCHLOPRAMIDE TABLETS/INJECTION #	1	2	3	4	5
28	CHLORPHENIRAMINE TABLETS #	1	2	3	4	5
29	PHENIRAMINE INJECTION #	1	2	3	4	5
30	CETRIZINE (TABS/SUSPENSION) #	1	2	3	4	5
31	ALUMINIUM HYDROXIDE + MAGNESIUM HYDROXIDE TABLETS (ANTACID) #	1	2	3	4	5
32	HYOSCINE BUTYLBROMIDE (TABS/INJECTION) #	1	2	3	4	5
33	PHENOBARBITONE TABLETS #	1	2	3	4	5
34	PROMETHAZINE HYDROCHLORIDE TABLETS #	1	2	3	4	5
35	ALPRAZOLAM TABLETS #	1	2	3	4	5
36	CHLORPROMAZINE TABLETS #	1	2	3	4	5
37	DIGOXIN TABLETS #	1	2	3	4	5
38	ALLOPURINOL TABLETS #	1	2	3	4	5
39	CARBAMAZEPINE TABLETS #	1	2	3	4	5
40	OXYMETAZOLINE NASAL DROPS #	1	2	3	4	5
41	ACETAZOLAMIDE TABLETS #	1	2	3	4	5
42	LEVOTHYROXIN TABLETS #	1	2	3	4	5
43	AMINOPHYLLINE TABLETS #	1	2	3	4	5

ANTI-FUNGAL MEDICINES

904*	Are any of the following **anti-fungal medicines** available in the facility/location today?	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
	CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK/ NEVER AVAILABLE
01*	FLUCONAZOLE TABLETS/OINTMENT #	1	2	3	4	5
02	MICONAZOLE VAGINAL PESSARIES	1	2	3	4	5
03	MICONAZOLE CREAM	1	2	3	4	5
04	NYSTATIN ORAL SUSPENSION	1	2	3	4	5
05	NYSTATIN VAGINAL PESSARIES/CREAM	1	2	3	4	5
06	COTRIMAZOLE SKIN CREAM #	1	2	3	4	5
07	COTRIMAZOLE PESSARY TAB #	1	2	3	4	5

ANTIMALARIAL MEDICINES

905*	Are any of the following **antimalarial** medicines available in the facility/location today?	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
	CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE
01	ARTEMETHER LUMEFRANTRINE (ALU) TABLETS/PACK	1	2	3	4	5
05	SULFADOXINE + PYRIMETHAMINE (SP)	1	2	3	4	5
06	QUININE TABLETS	1	2	3	4	5
07	QUININE INJECTION	1	2	3	4	5
08	INJECTABLE ARTESUNATE	1	2	3	4	5
10	OTHER ANTI-MALARIAL MEDICINE [OTHER THAN ARTESUNATE + AMODIAQUINE TABS]	1	2	3	4	5
11	CHLOROQUINE TABLETS	1	2	3	4	5
12*	PRIMAQINE TABLETS	1	2	3	4	5

MEDICINES FOR TREATMENT OF KALAAZAR / LEISHMANIASIS

'905A	Are any of the following medicines for treatment for Kalazaar / Leishmaniasis available in the facility today?	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
	CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE
01	TAB MILTEFOSINE	1	2	3	4	5
02	INJ. AMPHOTERICIN B	1	2	3	4	5
03	INJ. LIPOSOMAL AMPHOTERICIN B	1	2	3	4	5
04	COMBINATION (MILTEFOSINE + PARAMYCIN)	1	2	3	4	5

MATERNAL AND CHILD HEALTH

906*	Are any of the following medicines for **maternal health and child** available in the facility/location today?	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
	CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE
01	CALCIUM GLUCONATE INJECTION	1	2	3	4	5
02	FOLIC ACID TABLETS #	1	2	3	4	5
03	IRON TABLETS #	1	2	3	4	5
04	IRON + FOLIC ACID COMBINATION TABLET #	1	2	3	4	5
05	MAGNESIUM SULPHATE INJECTION	1	2	3	4	5
06	MISOPROSTOL TABLETS/CAPSULES	1	2	3	4	5
07	OXYTOCIN OR OTHER INJECTABLE UTEROTONIC	1	2	3	4	5
08*	TETANUS DIPHTERIA TOXOID VACCINE	1	2	3	4	5
09	ORAL REHYDRATION SALTS (ORS) SACHETS #	1	2	3	4	5
10	VITAMIIN A CAPSULES	1	2	3	4	5
11	ZINC TABLETS #	1	2	3	4	5
12*	INJECTION VITAMIN K	1	2	3	4	5
13*	MEDICAL ABORTION COMBI-PACK (MIFEPRISTONE 200mg + MISOPROSTOL 800 microgram vaginal tablets)	1	2	3	4	5

INTRAVENOUS FLUIDS

907	Are any of the following **intravenous fluids** available in the facility/location today?	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE
01	NORMAL SALINE / SODIUM CHLORIDE INJECTABLE SOLUTION #	1	2	3	4	5
02	RINGERS LACTATE #	1	2	3	4	5
03	5% DEXTROSE - NORMAL SALINE	1	2	3	4	5

FEVER REDUCING AND PAIN MEDICINES

908*	Are any of the following **OTHER medicines** available in the facility/location today?	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
	CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE
01	DICLOFENAC TABLETS/INJECTION (Strong oral pain medicine) #	1	2	3	4	5
02	PARACETAMOL TABLETS/INJECTION #	1	2	3	4	5
03	PARACETAMOL SYRUP OR DISPERSIBLE PEDIATRIC-DOZED TABLETS #	1	2	3	4	5
04	IBUPROFEN TABLETS #	1	2	3	4	5
05	INDOMETHACIN TABLETS #	1	2	3	4	5

OTHERS

908A	Are any of the following **OTHER medicines** available in the facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE
01	ACYCLOVIR TABS/OINTMENT (ANTIVIRAL) #	1	2	3	4	5
02	TINIDAZOLE TABLETS (ANTI-PROTOZOAL) #	1	2	3	4	5
03	VITAMIN B COMPLEX #	1	2	3	4	5
04	CALAMINE LOTION #	1	2	3	4	5
05	GAMMA BENZENE HEXACHLORIDE LOTION #	1	2	3	4	5
06	BENZOIC ACID + SALICYLIC ACID OINTMENT #	1	2	3	4	5
07	SILVER SULPHADIAZINE CREAM #	1	2	3	4	5
08	GENTIAN VIOLET SOLUTION (2%) #	1	2	3	4	5
09	POVIDONE IODINE #	1	2	3	4	5
10	CLOVE OIL #	1	2	3	4	5
11	ATROPINE INJECTION #	1	2	3	4	5
12	PALIDOXIME SODIUM #	1	2	3	4	5
13	ACTIVATED CHARCOAL #	1	2	3	4	5
14	LIGNOCAINE INJECTION #	1	2	3	4	5

STORAGE CONDITION: ANTIBIOTICS & GENERAL MEDICINES

909	OBSERVE THE PLACE WHERE THE MEDICINES ASSESSED SO FAR ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OF EACH OF THE FOLLOWING STORAGE CONDITIONS.	YES	NO
01	ARE THE MEDICINES OFF THE FLOOR?	1	2
02	ARE THE MEDICINES PROTECTED FROM WATER	1	2
03	ARE THE MEDICINES PROTECTED FROM THE SUN?	1	2
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC)?	1	2
05	IS THE STORAGE ROOM WELL VENTILATED?	1	2

910	ARE THE MEDICINES ORGANIZED ACCORDING TO DATE OF EXPIRATION ("first expire, first out")?	YES, ALL MEDICINES. . . . . 1 YES, ONLY SOME MEDICINES. . . . . 2 NO. 3	
911	What system does this facility use to monitor the amount of medicines received, the amount issued, and the amount present today? ASK TO SEE THE SYSTEM AND RECORD OBSERVATION	COMPUTER SYSTEM UPDATED DAILY. . . . . 1 LEDGER/STOCK CARD UPDATED DAILY. . . . . 2 COMPUTER SYSTEM NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED MEDICINES. . . . . 3 LEDGER/STOCK CARD NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED MEDICINES. . . . . 4 OTHER SYSTEM (SPECIFY)_____ 6	

SUPPLY ITEMS

912	Do you have the following supply items available in the facility/location today?	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	SINGLE-USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR AUTO-DESTRUCT SYRINGES WITH NEEDLES	1	2	3
02	INFUSION SET FOR IV SOLUTION	1	2	3
03	CANULA FOR ADMINISTERING IV FLUIDS	1	2	3
04	LATEX GLOVES	1	2	3
05	ALCOHOL-BASED HAND RUB	1	2	3
06	HAND WASHING SOAP	1	2	3
07	DISINFECTING SOLUTION	1	2	3
08	INSECTICIDE TREATED MOSQUITO NETS	1	2	3
912A*	Do you have the following items available in the facility/location today?	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	Refrigerator for storage of drugs that need refrigeration. This is a refrigerator other than the refrigerator for storing vaccines, and even the refrigerator for storing blood.	1	2	3
02	Thermometer to monitor room temperature where drugs are stored	1	2	3

SECTION 9.2: CONTRACEPTIVE COMMODITIES

920	**CHECK Q212** CONTRACEPTIVES STORED WITH OTHER MEDICINES IN COMMON LOCATION **(RESPONSE 2 CIRCLED)** →	CONTRACEPTIVES STORED IN FP SERVICE AREA OR NOT STOCKED AT ALL IN FACILITY **(RESPONSE 1 OR 3 CIRCLED)** → PROCEED TO NEXT SECTION **(TB MEDS?)**

	Are any of the following **CONTRACEPTIVE** commodities available in the facility/ location today?	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED			(C) OUT OF STOCK IN LAST SIX MONTHS		
	CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE	YES	NO	DK
01*	COMBINED ORAL CONTRACEPTIVE PILLS (OCP)	1	2	3	4	5 → 02	1	2	8
02	PROGESTIN-ONLY CONTRACEPTIVE PILLS	1	2	3	4	5 → 04	1	2	8
04	PROJESTIN-ONLY INJECTABLE CONTRACEPTIVES (DEPO)	1	2	3	4	5 → 05	1	2	8
05	MALE CONDOMS	1	2	3	4	5 → 07	1	2	8
07*	INTRAUTERINE CONTRACEPTIVE DEVICE (COPPER-T)	1	2	3	4	5 → 08	1	2	8
08*	IMPLANT (ZEDEL)	1	2	3	4	5 → 09	1	2	8
09*	EMERGENCY CONTRACEPTIVE PILLS (E.G., PROSTINOL 2, ECP)	1	2	3	4	5 → 922	1	2	8

STORAGE CONDITION - CONTRACEPTIVE COMMODITIES

	OBSERVE THE LOCATION WHERE CONTRACEPTIVE COMMODITIES ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OF EACH OF THE FOLLOWING STORAGE CONDITIONS	YES	NO
922			
01	ARE THE COMMODITIES OFF THE FLOOR?	1	2
02	ARE THE COMMODITIES PROTECTED FROM WATER	1	2
03	ARE THE COMMODITIES PROTECTED FROM THE SUN?	1	2
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC)?	1	2
05	IS THE STORAGE ROOM WELL VENTILATED?	1	2

923	ARE THE CONTRACEPTIVE COMMODITIES ORGANIZED ACCORDING TO DATE OF EXPIRATION ("first expire, first out")	YES, ALL COMMODITIES. . . . . 1 NOT ALL COMMODITIES. . . . . 2 NO. 3	
924	What type of system does this facility use to monitor the amount of contraceptive commodities received, the amount issued, and the amount present today? ASK TO SEE THE SYSTEM AND RECORD OBSERVATION	COMPUTER SYSTEM UPDATED DAILY. . . . . 1 LEDGER/STOCK CARD UPDATED DAILY. . . . . 2 COMPUTER SYSTEM NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED COMMODITIES. . . . . 3 LEDGER/STOCK CARD NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED COMMODITIES. . . . . 4 OTHER SYSTEM _____ (SPECIFY) 6	
924A	When was the last time that you received a routine supply of contraceptive methods?	WITHIN PRIOR 4 FULL WEEKS 1 BETWEEN 4-12 WEEKS . . . . . 2 MORE THAN 12 WEEKS AGO . . . . 3 NO ROUTINE SUPPLY SYSTEM . . . . . 4 DON'T KNOW 8	
924B	Does this facility determine the quantity of each contraceptive method required and order that, or is the quantity that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS . . . . . 1 NEED DETERMINED ELSEWHERE . . . . . 2 → 925 BOTH (DIFFER BY COMMODITY) . . . . . 3 DON'T KNOW . . . . . 8 → 925	

924C	Routinely, when you order contraceptive methods, which best describes the system you use to determine **how much** of each to order? Do you: - **Review** the amount of each method remaining, and order to bring the stock amount to a pre-determined (fixed) amount? - **Order** exactly the same quantity each time, regardless of the existing stock? - **Review** the amount of each method used since the previous order, and plan based on prior utilization and expected future activity? - **Other** _____ (SPECIFY) DON'T KNOW	ORDER TO MAINTAIN FIXED STOCK . . . . . 1 ORDER SAME AMOUNT . . . . . 2 ORDER BASED ON UTILIZATION . . . . . 3 OTHER . . . . . 6 DON'T KNOW . . . . . 8 → 925	
924D	On average approximately how long does it take between ordering and receiving family planning commodities for this faciltity?	< 2 WEEKS . . . . . 1 ≥ 2 WEEKS BUT NOT UP TO ONE MONTH . . . . . 2 ≥ 1 MONTH BUT NOT UP TO 2 MONTHS . . . . . 3 ≥ 2 MONTH BUT NOT UP TO 4 MONTHS . . . . . 4 ≥ 4 MONTH BUT NOT UP TO 6 MONTHS 5	
925	PRESENTLY INTERVIEWING IN PHARMACY ☐ PROCEED TO NEXT SECTION OR SERVICE SITE ←	PRESENTLY INTERVIEWING IN FAMILY PLANNING SERVICE AREA ☐ THANK THE RESPONDENT IN THE FP SERVICE AREA AND CONTINUE TO NEXT SECTION OR SERVICE SITE ←	

SECTION 9.3: ANTI-TB DRUGS

930	**CHECK Q214** ANTI-TB MEDICINES STORED WITH OTHER MEDICINES IN COMMON LOCATION **(RESPONSE 2 CIRCLED)** ☐ ↓ ANTI-TB MEDICINES STORED IN TB SERVICE AREA OR NOT STOCKED AT ALL IN FACILITY **(RESPONSE 1 OR 3 CIRCLED)** ☐ ↓ PROCEED TO NEXT SECTION **(ARV MEDS?)** ←					
931	Are any of the following TB medicines available in the facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE
01	ETHAMBUTOL TABS (E)	1	2	3	4	5
02	ISONIAZID TABS (INH, H)	1	2	3	4	5
03	PYRAZINAMIDE (Z)	1	2	3	4	5
04	RIFAMPICIN (R)	1	2	3	4	5
05	ISONIAZID + RIFAMPICIN	1	2	3	4	5
06	ISONIAZID + ETHAMBUTOL (EH) (2FDC)	1	2	3	4	5
07	ISONIAZID + RIFAMPICIN + PYRAZINAMIDE (RHZ) (3FDC)	1	2	3	4	5
08	ISONIAZID + RIFAMPICIN + ETHAMBUTOL (RHE) (3FDC)	1	2	3	4	5
09	ISONIAZID + RIFAMPICIN + PYRAZINAMIDE + ETHAMBUTOL (4FDC)	1	2	3	4	5
10	STREPTOMYCIN INJECTABLE	1	2	3	4	5

STORAGE CONDITION: ANTI-TB MEDICINES

932*	OBSERVE THE PLACE WHERE THE TB MEDICINES ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OF EACH OF THE FOLLOWING STORAGE CONDITIONS.	YES	NO
01	ARE THE MEDICINES OFF THE FLOOR?	1	2
02	ARE THE MEDICINES PROTECTED FROM WATER	1	2
03	ARE THE MEDICINES PROTECTED FROM THE SUN?	1	2
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC)?	1	2
05	IS THE STORAGE ROOM WELL VENTILATED?	1	2
06	ARE THE MEDICINES PROTECTED FROM MOISTURE/HUMIDITY?	1	2

933	ARE THE MEDICINES ORGANIZED ACCORDING TO DATE OF EXPIRATION ("first expire, first out")?	YES, ALL MEDICINES. . . . . 1 YES, ONLY SOME MEDICINES. . . . . 2 NO. 3	
934	What system does this facility use to monitor the amount of medicines received, the amount issued, and the amount present today? ASK TO SEE THE SYSTEM AND RECORD OBSERVATION	COMPUTER SYSTEM UPDATED DAILY. . . . . 1 LEDGER/STOCK CARD UPDATED DAILY. . . . . 2 COMPUTER SYSTEM NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED VACCINES. . . . . 3 LEDGER/STOCK CARD NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED MEDICINES. . . . . 4 OTHER SYSTEM _____ (SPECIFY) 6	
935	PRESENTLY INTERVIEWING IN PHARMACY ☐ ↓ PROCEED TO NEXT SECTION OR SERVICE SITE ← PRESENTLY INTERVIEWING IN TB SERVICE AREA ☐ ↓ THANK THE RESPONDENT IN THE TB SERVICE AREA AND CONTINUE TO NEXT SECTION OR SERVICE SITE ←		

SECTION 9.4: ANTIRETROVIRAL MEDICINES

940	**CHECK Q216** ARV MEDICINES STORED WITH OTHER MEDICINES IN COMMON LOCATION **(RESPONSE 2 CIRCLED)** → PROCEED TO NEXT SECTION ARV MEDICINES STORED IN ART SERVICE AREA OR NOT STOCKED AT ALL IN FACILITY **(RESPONSE 1 OR 3 CIRCLED)** → PROCEED TO NEXT SECTION					
941*	Are any of the following Nucleoside Reverse Transcriptase Inhibitor (NTRI) ARVs available in the facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE
01	ZIDOVUDINE (ZDV, AZT) TABLETS	1	2	3	4	5
02	ZIDOVUDINE (ZDV, AZT) SYRUP OR DISPERSIBLE TABLETS	1	2	3	4	5
03	ABACAVIR (ABC) TABLETS	1	2	3	4	5
04*	DIDANOSINE (ddI) CAP	1	2	3	4	5
05	LAMIVUDINE (3TC) TABLETS	1	2	3	4	5
06	LAMIVUDINE (3TC) SYRUP	1	2	3	4	5
07	STAVUDINE 30 (D4T)	1	2	3	4	5
08	STAVUDINE SYRUP	1	2	3	4	5
09	TENOFOVIR DISOPROXIL FUMARATE (TDF)	1	2	3	4	5
942*	Are any of the following **Non-Nucleoside Reverse Transcriptase Inhibitor (NNRTI)** ARVs available in the facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE
01	NEVIRAPINE (NVP) TABLETS	1	2	3	4	5
02	NEVIRAPINE (NVP) SYRUP	1	2	3	4	5
03	EFAVIRENZ (EFV) TABLETS/CAPSULES	1	2	3	4	5
04	EFAVIRENZ (EFV) SYRUP	1	2	3	4	5
943*	Is the following **Protease Inhibitor** ARV available in this facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE
10*	LOPINAVIR (LPV) + RITONAVIR (RTV)	1	2	3	4	5

944*	Are any of the following **Fusion Inhibitor or Combined ARVs** available in this facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE
02	STAVUDINE + LAMIVUDINE [D4T + 3TC]	1	2	3	4	5
03	STAVUDINE + LAMIVUDINE + NEVIRAPINE [D4T + 3TC + NVP]	1	2	3	4	5
04	ZIDOVUDINE + LAMIVUDINE [AZT + 3TC]	1	2	3	4	5
05	ZIDOVUDINE + LAMIVUDINE + ABACAVIR [AZT + 3TC + ABC]	1	2	3	4	5
06	ZIDOVUDINE + LAMIVUDINE + NEVIRAPINE [AZT + 3TC + NVP]	1	2	3	4	5
08	TENOFOVIR + LAMIVUDINE [TDF + 3TC]	1	2	3	4	5
09	TENOFOVIR + LAMIVUDINE + EFAVIRENZ [TDF + 3TC + EFV]	1	2	3	4	5

STORAGE CONDITION - ARV MEDICINES

945	OBSERVE THE LOCATION WHERE ARVs ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OF EACH OF THE FOLLOWING STORAGE CONDITIONS	YES	NO
01	ARE THE ARVs OFF THE FLOOR?	1	2
02	ARE THE ARVs PROTECTED FROM WATER	1	2
03	ARE THE ARVs PROTECTED FROM THE DIRECT SUN LIGHT?	1	2
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC)?	1	2
05	IS THE STORAGE ROOM WELL VENTILATED?	1	2

946*	ARE THE ARVS ORGANIZED ACCORDING TO DATE OF EXPIRATION ("first expire, first out"; " FEFO")	YES, ALL MEDICINES. . . . . 1 YES, ONLY SOME MEDICINES. . . . . 2 NO. 3	
947	What system does this facility use to monitor the amount of ARV medicines received, the amount issued, and the amount present today? ASK TO SEE THE SYSTEM AND RECORD OBSERVATION	COMPUTER SYSTEM UPDATED DAILY. . . . . 1 LEDGER/STOCK CARD UPDATED DAILY. . . . . 2 COMPUTER SYSTEM NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED ARVS. . . . . 3 LEDGER/STOCK CARD NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED ARVS. . . . . 4 OTHER SYSTEM _____ 6 (SPECIFY)	
948	PRESENTLY INTERVIEWING IN PHARMACY ☐ PROCEED TO NEXT SECTION OR SERVICE SITE ←	PRESENTLY INTERVIEWING IN ART SERVICE AREA ☐ THANK THE RESPONDENT IN THE ART SERVICE AREA AND CONTINUE TO NEXT SECTION OR SERVICE SITE ←	

MODULE 3: SERVICE-SPECIFIC READINESS

CHILD HEALTH SERVICES

SECTION 10: CHILD VACCINATION

1000	**CHECK Q102.01** CHILD VACCINATION SERVICES AVAILABLE ☐ ↓ NO CHILD VACCINATION SERVICES ☐ → NEXT SECTION OR SERVICE SITE	

ASK TO BE SHOWN THE MAIN LOCATION WHERE CHILD VACCINATION SERVICES ARE PROVIDED IN THE FACILITY.
FIND THE PERSON MOST KNOWLEDGEABLE ABOUT CHILD VACCINATION SERVICES IN THE FACILITY.
INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

1001* Now I would like to ask you specifically about vaccination services for children under 5 years. For each of the following services, please tell me whether the service is offered by your facility, and if so, *how many days* per month the service is provided *at the facility, and how many days per month as outreach, if any.*

	CHILD VACCINATION SERVICE (USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	(a) # OF DAYS PER MONTH SERVICE IS PROVIDED AT FACILITY	(b) # OF DAYS PER MONTH SERVICE IS PROVIDED THROUGH OUTREACH
01	Routine DPT+HepB+Hib (**pentavalent**)	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
02	Routine polio vaccination	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
03	Routine MR vaccination	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
04	BCG vaccination	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
05*	Pneumococcal Vaccination (PCV)	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
06*	Japanese encephalitis vaccination (JE Vaccination)	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐

1002*	Do you have the national immunization manual for child vaccinations available in this service area today?	YES . . . . . 1 NO 2	→ 1004
1003*	May I see the national immunization manual for child vaccinations?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	→ 1006
1004*	Do you have ***any other guidelines*** for child vaccinations (i.e. Khopko Byawaharik Gyan 2070, Measles Rubella Khop sambandhi Nirdeshika) available in this service area today?	YES . . . . . 1 NO 2	→ 1006
1005*	May I see these guidelines?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	

1006*	ASK YOUR RESPONDENT TO SHOW YOU ITEMS REQUIRED FOR VACCINATION SERVICES	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	Blank/unused individual child vaccination cards or booklets	1	2	3	
02	Tally sheets	1	2	3	
04*	FCHV report forms (HMIS 9.1)	1	2	3	
05*	Immunization and outreach clinic programme report (HMIS 9.2)	1	2	3	
06*	Monthly progress report (HMIS 9.3) (IF SHP, HP , PHC)	1	2	3	
07*	Hospital monthly progress report (HMIS 9.4) (IF PUBLIC HOSPITAL)	1	2	3	
08*	Immunization register	1	2	3	

1007*	Does this facility routinely store any vaccines, or are all its vaccines either picked up from another facility or delivered when services are being provided?	ROUTINELY STORE SOME VACCINES. . . . . 1 RECEIVE ALL VACCINES FROM HIGHER CENTER AND STORES FOR SHORT TIME. 3 STORES NO VACCINES. 2	→ 1014 → 1014
1008	ASK TO BE TAKEN TO THE AREA WHERE VACCINES ARE STORED. ASK TO SEE THE VACCINE REFRIGERATOR.	REFRIGERATOR OBSERVED. . . . . 1 REFRIGERATOR NOT OBSERVED. 2	→ 1014
1009	Do you maintain a cold-chain temperature monitoring chart?	YES. . . . . 1 NO 2	→ 1012
1010	May I see the cold-chain temperature monitoring chart?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	→ 1012
1011	CHECK WHETHER THE TEMPERATURE RECORD WAS COMPLETED TWICE DAILY FOR EACH OF THE PAST 30 DAYS, INCLUDING WEEKENDS AND PUBLIC HOLIDAYS.	YES, COMPLETED . . . . . 1 NO, NOT COMPLETED 2	

		(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
1012*	Please tell me if each of the following vaccines is available in the facility today. If available, I would like to see it. IF AVAILABLE, CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED, VVM UNCHANGED, NOT FROZEN) (May be available on vaccination days only?)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NEVER AVAILABLE
01	DPT+HepB+Hib [PENTAVALENT]	1	2	3	4	5
02*	ORAL POLIO VACCINE/ IPV	1	2	3	4	5
03	MR VACCINE AND DILUENT	1	2	3	4	5
04	BCG VACCINE AND DILUENT	1	2	3	4	5
05*	PNEUMOCOCCAL CONJUGATE VACCINE (PCV 13)	1	2	3	4	5
06*	JAPANESE ENCEPHALITIS VACCINE (JE VACCINE)	1	2	3	4	5

1013	WHAT IS THE TEMPERATURE IN THE VACCINE REFRIGERATOR?	BETWEEN +2 AND +8 DEGREES. . . . . 1 ABOVE +8 DEGREES. . . . . 2 BELOW +2 DEGREES. . . . . 3 THERMOMETER NOT FUNCTIONAL. . . . . 4 NO THERMOMETER 5	
1014*	How many vaccine carriers or cold boxes do you have? ASK TO SEE THE VACCINE CARRIERS. REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT IS ACCEPTABLE.	ONE 1 TWO OR MORE SETS. . . . . 2 NONE. 3	→ 1015B
1015*	How many sets of ice packs or cool water packs do you have? ASK TO SEE THE ICE PACKS. REPORTED RESPONSEACCEPTABLE **NOTE: 4-5 ICE PACKS MAKE ONE SET**	ONE SET. . . . . 1 TWO OR MORE SETS. . . . . 2 NO ICE PACKS, USE PURCHASED ICE. . . . . 3 NO ICE PACKS. 4	→ 1015B

1015A	OBSERVE ICEPACKS CONDITIONING.	ICEPACK CONDITIONING MAINTAINED . . . . . 1 NOT MAINTAINED 2	
1015B	Does this facility have vaccine bundling system? (Syringe, Icepacks, Diluent, Safety Boxes and Re-constitution Syringe)	YES. . . . . 1 NO. 2	→ 1015D
1015C	May I see vaccine bundling commodities? OBSERVE IF COMMODITIES BUNDLING (MANAGED BY THE FACILITY) IS ACCORDING TO THE DOSES OF VACCINES.	OBSERVED. . . . . 1 REPORTED, NOT SEEN. . . . . 2 NOT AVAILABLE (NOT VACCINATION DAY) . . 3	
1015D	Do you follow multi dose-vial policy (MDVP) ?	YES. . . . . 1 NO. 2	
1015E	Do you follow vaccine vial monitoring (VVM) ?	YES. . . . . 1 NO. 2	
1015F	Does this facility use the Adverse Effect Following Immunization (AEFI) form to report vaccine-related adverse effects?	YES. . . . . 1 NO. 2	→ 1050
1015G	May I see a copy of the form?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. . . . . 2 NOT AVAILABLE 3	

INFECTION CONTROL

1050	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY [Q1651]. . . . . 17 STI SERVICES [Q1851] . . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. . . . . 31 → NEXT SECTION / SERVICE SITE

1051*	**INFECTION CONTROL AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04*	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND COLOR CODED PLASTIC BIN LINER / LABELED BIN (RED, GREEN, YELLOW AND BLUE)	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT/ANTISEPTICS [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE-USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR AUTO-DISABLE SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13*	INJECTION SAFETY PRECAUTION GUIDELINES FOR STANDARD PRECAUTIONS (Surakchhit sui ko niti)	1	2	3
14*	NEEDLE DESTROYER	1	2	3
15*	METHYLATED SPIRIT AND GLYCIRINE 70:30	1	2	3

1052	DESCRIBE THE SETTING OF THE CHILD VACCINATION SERVICE DELIVERY ROOM OR AREA.	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4	

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 11: CHILD GROWTH MONITORING SERVICES

1100	**CHECK Q102.02**	GROWTH MONITORING SERVICES AVAILABLE ☐	NO GROWTH MONITORING SERVICES ☐ → NEXT SECTION OR SERVICE SITE

ASK TO BE SHOWN THE MAIN LOCATION WHERE GROWTH MONITORING SERVICES ARE PROVIDED IN THE FACILITY. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT GROWTH MONITORING SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

		(a) # OF DAYS PER MONTH SERVICE IS PROVIDED AT FACILITY	(b) # OF DAYS PER MONTH SERVICE IS PROVIDED THROUGH OUTREACH
1101	Please tell me the number of days per month that growth monitoring services are offered in this facility, and the number of days per month as outreach, if any. USE A 4-WEEK MONTH TO CALCULATE # OF DAYS		
01	Child growth monitoring	# OF DAYS ☐☐	# OF DAYS 00=NO SERVICE ☐☐

1102	Do you have the HMIS instruction for growth monitoring available in this service area today? (HMIS user manual)	YES. . . . . 1 NO GUIDELINE AVAILABLE. 2	→ 1104
1103	May I see the HMIS instruction for growth monitoring?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	

1104*	I would like to know if the following items are available in this service area and are functioning. I would like to see them.	(A) AVAILABLE: OBSERVED	(A) AVAILABLE: REPORTED NOT SEEN	(A) AVAILABLE: NOT AVAILABLE	(B) FUNCTIONING: YES	(B) FUNCTIONING: NO	(B) FUNCTIONING: DON'T KNOW
01	CHILD WEIGHING SCALE (250GRAM GRADATION)	1 b	2 b	3 → 02	1	2	8
02	INFANT WEIGHING SCALE (100 GRAM GRADATION)	1 b	2 b	3 → 03	1	2	8
03	HEIGHT OR LENGTH BOARD	1 b	2 b	3 → 04	1	2	8
04	TAPE FOR MEASURING HEAD CIRCUMFERENCE	1 b	2 b	3 → 05	1	2	8
05	GROWTH CHARTS (HMIS 2.1)	1	2	3			
06*	TAPE FOR MID-UPPER ARM CIRCUMFERENCE (MUAC) (SAKIR TAPE)	1 b	2 b	3 → NEXT SECTION	1	2	8

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 12: CHILD CURATIVE CARE SERVICES

1200	**CHECK Q102.03**	CURATIVE CARE SERVICES AVAILABLE ☐	NO CURATIVE CARE SERVICES ☐ NEXT SECTION OR SERVICE SITE ←	

ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE CURATIVE CARE SERVICES ARE PROVIDED.
FIND THE PERSON MOST KNOWLEDGEABLE ABOUT CURATIVE CARE SERVICES IN THE FACILITY.
INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

		(a) # OF DAYS PER MONTH SERVICE IS PROVIDED AT FACILITY	(b) # OF DAYS PER MONTH SERVICE IS PROVIDED THROUGH OUTREACH (VILLAGE LEVEL) ACTIVITIES
1201	Please tell me the number of days per month that consultations or curative care for children under 5 are offered in this facility, and the number of days per month as outreach, if any. USE A 4-WEEK MONTH TO CALCULATE # OF DAYS		
01	Consultation or curative care services for sick children	# OF DAYS ☐☐	# OF DAYS 00=NO SERVICE ☐☐

		YES	NO
1202*	Please tell me if providers of child health services in this facility provide the following services		
01	DIAGNOSE AND/OR TREAT CHILD MALNUTRITION	1	2
02	PROVIDE VITAMIN A SUPPLEMENTATION TO CHILDREN	1	2
04	PROVIDE ZINC SUPPLEMENTATION TO CHILDREN	1	2
05*	PROVIDE DEWORMING TO SCHOOL CHILDREN	1	2
06*	PROVIDE BALVITA, MICRONUTRIENT POWDER (MNP)	1	2

1203	Do providers of services for sick children in this facility follow the IMNCI guidelines in the provision of services to children under 5 years?	YES. . . . . 1 NO 2	
1204	Do you have the ***IMNCI guidelines (chart booklet)*** for the diagnosis and management of childhood illnesses available in this service area today?	YES. . . . . 1 NO 2	→ 1206
1205	May I see the IMNCI guidelines?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	→ 1208
1206	Do you have ***any (other) guidelines*** for the diagnosis and management of childhood illnesses available in this service site today?	YES. . . . . 1 NO 2	→ 1208
1207	May I see the other guidelines?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1208	Does this facility have a system whereby certain observations and parameters are routinely carried out on sick children before the consultation for the presenting illness? IF YES, ASK TO SEE THE PLACE WHERE THESE ACTIVITIES TAKE PLACE BEFORE THE CONSULTATION	YES. . . . . 1 NO 2	→ 1210

1209	OBSERVE IF THE BELOW ACTIVITIES ARE BEING DONE ROUTINELY. IF YOU DO NOT SEE AN ACTIVITY, ASK: Is [ACTIVITY YOU DO NOT SEE] routinely conducted for all sick children?	ACTIVITY OBSERVED	ACTIVITY REPORTED NOT SEEN	ACTIVITY NOT ROUTINELY CONDUCTED	DON'T KNOW
01	Weighing the child	1	2	3	8
02	Plotting child's weight on graph (e.g. HMIS card, child health card)	1	2	3	8
03	Taking child's temperature	1	2	3	8
04	Assessing child's vaccination status	1	2	3	8
05	Providing group health education	1	2	3	8
06	Administer fever-reducing medicines and/or sponge for fever	1	2	3	8
07	Triaging of sick children, i.e., prioritizing sick children based on the severity of their condition	1	2	3	8

		(A) AVAILABLE			(B) FUNCTIONING		
1210	I would like to know if the following items are available in this service area. I would like to see them. For equipment and instruments, I would like to know if they are functioning.	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	CHILD WEIGHING SCALE (250GRAM GRADATION)	1 b	2 b	3 → 02	1	2	8
02	INFANT WEIGHING SCALE (100 GRAM GRADATION)	1 b	2 b	3 → 03	1	2	8
03	THERMOMETER	1 b	2 b	3 → 04	1	2	8
04	STETHOSCOPE	1 b	2 b	3 → 05	1	2	8
05	Timer or watch with seconds hand	1 b	2 b	3 → 06	1 → 07	2	8
06	Staff has watch with seconds hand or other device (e.g., cell phone) that can measure seconds	1 b	2 b	3 → 07	1	2	8
07	Calibrated 1/2 or 1-liter measuring jar for ORS	1	2	3			
08	Cup and spoon	1	2	3			
09	ORS PACKETS OR SACHETS	1	2	3			
10	At least 1 bucket (for cleaning used cups)	1	2	3			
11	Examination bed or table	1 → b	2 → b	3 → 1211	1	2	8
1211*	Please tell me if you have any of the following materials. IF YES, ASK TO SEE						
01	IMNCI chart booklet	1	2	3			
02	IMNCI mother's cards	1	2	3			
03	Other visual aids for teaching caretakers	1	2	3			
04*	IEC materials on Infant and Young Child Feeding (IYCF)	1	2	3			
05*	IEC materials on IMCI?	1	2	3			

1212*	Are health records (register) for sick children maintained at this service site?	YES. . . . . 1 NO 2	→ 1250
1213*	May I see the register?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	

INFECTION CONTROL

1250	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051]. . . . . 12 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY [Q1651]. . . . . 17 STI SERVICES [Q1851] . . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. 31	NEXT SECTION / SERVICE SITE

	INFECTION CONTROL AND CONDITIONS FOR CLIENT EXAMINATION	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04*	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND COLOR CODED PLASTIC BIN LINER / LABELED BIN (RED, GREEN, YELLOW AND BLUE)	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT/ANTISEPTICS [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE-USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR AUTO-DISABLE SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13*	INJECTION SAFETY PRECAUTION GUIDELINES FOR STANDARD PRECAUTIONS (Surakchhit sui ko niti)	1	2	3
14*	NEEDLE DESTROYER	1	2	3
15*	METHYLATED SPIRIT AND GLYCIRINE 70:30	1	2	3

1252	DESCRIBE THE SETTING OF THE SICK CHILD SERVICE DELIVERY ROOM OR AREA.	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4	
	THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.		

SECTION 13: FAMILY PLANNING

1300	**CHECK Q102.04** FAMILY PLANNING SERVICES ☐		NO FAMILY PLANNING SERVICES ☐ NEXT SECTION OR SERVICE SITE		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE FAMILY PLANING SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT FAMILY PLANNING SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.				
1301	How many days in a month are family planning services offered at this facility? USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	NUMBER OF DAYS ☐☐			
1302*	Does this facility ***provide*** (i.e., stock the commodity) or ***prescribe, counsel or refer clients for*** any of the following modern methods of family planning:	PROVIDE (STOCK THE COMMODITY)	PRESCRIBE/ COUNSEL, OR REFER	NO	
01*	COMBINED ORAL CONTRACEPTIVE PILLS (OCP)	1	2	3	
02	PROGESTIN-ONLY CONTRACEPTIVE PILLS	1	2	3	
04	PROGESTIN-ONLY INJECTABLE CONTRACEPTIVES (DEPO)	1	2	3	
05	MALE CONDOMS	1	2	3	
07*	INTRAUTERINE CONTRACEPTIVE DEVICE (IUCD)(COPPER-T)	1	2	3	
08*	IMPLANT (ZEDEL / INDOPLANT)	1	2	3	
09*	EMERGENCY CONTRACEPTIVE PILLS (E.G., PROSTINOL 2, ECP)	1	2	3	
11	COUNSEL CLIENTS ON PERIODIC ABSTINENCE		2	3	
12	VASECTOMY (MALE STERILIZATION)	1	2	3	
13*	TUBAL LIGATION (FEMALE STERILIZATION, MINILAP)	1	2	3	
1303*	Do you have the ***national family planning guidelines*** (Nepal Medical Standard Contraceptive Services Volume I) available at this service area today?	YES. . . . . 1 NO. 2			→ 1305
1304*	May I see the national family planning guidelines?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2			→ 1307
1305*	Do you have ***other job aids*** on family planning available at this service area today?	YES. . . . . 1 NO. 2			→ 1307

1306*	May I see the other job aids on Family planning?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2			
1307	Are client records, cards or registers maintained at this service site for family planning clients?	YES. . . . . 1 NO. 2			→ 1309
1308*	May I see a blank copy of the the following:	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	Face sheet (HMIS 3.5)	1	2	3	
02*	Health Service Card (HMIS 1.2)	1	2	3	
03	Family planning Register (pills depo service register, IUCD / Implant service register, sterilization register) (HMIS 3.2, 3.3, 3.4)	1	2	3	
1309	Does this facility have a system whereby certain observations and parameters are routinely carried out on family planning clients before the consultation takes place? IF YES, ASK TO SEE THE PLACE WHERE THESE ACTIVITIES TAKE PLACE.	YES. . . . . 1 NO. 2			→ 1311
1310	OBSERVE IF THE BELOW ACTIVITIES ARE BEING DONE ROUTINELY. IF YOU DO NOT SEE AN ACTIVITY, ASK: Is [ACTIVITY YOU DO NOT SEE] routinely done for all family planning clients?	ACTIVITY OBSERVED	ACTIVITY REPORTED NOT SEEN	ACTIVITY NOT ROUTINELY DONE	DON'T KNOW
01	Weighing of clients	1	2	3	8
02	Taking blood pressure	1	2	3	8
03	Conducting group health education sessions	1	2	3	8
1311	Do family planning providers in this facility diagnose and treat suspected STIs, or are suspected STI clients referred to another provider or location for STI diagnosis and treatment? PROBE TO ARRIVE AT THE RIGHT ANSWER	DIAGNOSE AND TREAT STIs. . . . . 1 DIAGNOSE BUT REFER ELSEWHERE FOR TREATMENT. . . . . 2 REFER ELSEWHERE IN FACILITY FOR DIAGNOSIS AND TREATMENT. . . . . 3 REFER OUTSIDE FACILITY FOR DIAG & TREATMENT. 4 NO DIAGNOSIS / TREATMENT / REFERRAL. 5			

EQUIPMENT AND SUPPLIES

1314*	I would like to know if the following items are available in this service area today and are functioning	(A) AVAILABLE			(B) FUNCTIONING		
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	DIGITAL BP APPARATUS	1 → b	2 → b	3 → 02	1	2	8
02	MANUAL BP APPARATUS	1 → b	2 → b	3 → 03	1	2	8
03	STETHOSCOPE	1 → b	2 → b	3 → 04	1	2	8
04	EXAMINATION LIGHT (FLASHLIGHT OK)	1 → b	2 → b	3 → 05	1	2	8
05*	EXAMINATION BED OR TABLE	1 → b	2 → b	3 → 07	1	2	8
07	OTHER FP-SPECIFIC VISUAL AIDS [E.G., FLIP CHARTS, LEAFLETS]	1	2	3			
08	PELVIC MODEL FOR IUCD	1	2	3			
09	MODEL FOR SHOWING CONDOM USE	1	2	3			
10*	GOOSE LAMP	1 → b	2 → b	3 → 11	1	2	8
11*	FP KIT OR COUNSELLING KIT	1	2	3			

1315	**CHECK Q1302.07 & Q1302.08.** IUCD OR IMPLANT PROVIDED IN FACILITY ☐		NEITHER IUCD NOR IMPLANT PROVIDED IN FACILITY ☐ → 1321		
	ASK TO BE TAKEN TO THE ROOM OR LOCATION WHERE IUCDs AND/OR IMPLANTS ARE INSERTED OR REMOVED				
1316	Please show me the following items for the provision of IUCD or Implant methods:	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	STERILE GLOVES	1	2	3	
02	ANTISEPTIC SOLUTION	1	2	3	
03	SPONGE HOLDING FORCEPS	1	2	3	
04	STERILE GAUZE PAD OR COTTON WOOL	1	2	3	
1317	**CHECK Q1302.07** IUCD PROVIDED IN FACILITY ☐		IUCD NOT PROVIDED IN FACILITY ☐ → 1319		
1318	Please show me the following items for the provision of IUCD:	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	VAGINAL SPECULUM - SMALL	1	2	3	
02	VAGINAL SPECULUM - MEDIUM	1	2	3	
03	VAGINAL SPECULUM - LARGE	1	2	3	
04	TENACULA (VOLSELLUM FORCEPS)	1	2	3	
05	UTERINE SOUND	1	2	3	
1319	**CHECK Q1302.08.** IMPLANT PROVIDED IN FACILITY ☐		IMPLANT NOT PROVIDED IN FACILITY ☐ → 1321		
1320	Please show me the following items for the provision of Implant:	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	LOCAL ANESTHETIC	1	2	3	
02*	STERILE SYRINGE AND NEEDLE OR DISPOSABLE SYRINGE	1	2	3	
03	CANULA AND TROCHAR FOR INSERTING IMPLANT	1	2	3	
04	SEALED IMPLANT PACK	1	2	3	
05	SCAPEL WITH BLADE	1	2	3	
06	MINOR SURGERY KIT (E.G., WITH ARTERY FORCEPS)	1	2	3	
1321	Where are equipment such as specula or forceps that are used in the provision of family planning services processed for re-use?	FP SERVICE SITE. . . . . 1 CENTRAL LOCATION IN FACILITY. . . . . 2 → 1350 BOTH LOCATIONS. . . . . 3 NO EQUIPMENT PROCESSED IN FACILITY. . . . . 4 → 1350			
1322	What is the final processing method used for family planning equipment at this service site? PROBE FOR ALL METHODS USED	AUTOCLAVE. . . . . A DRY HEAT STERILIZATION. . . . . B SOAK IN CHLORINE SOLUTION. . . . . C BOIL OR STEAM. . . . . D WASH WITH SOAP AND WATER. . . . . E SOAK IN OTHER CHEMICAL SOLUTION. . . . F			

INFECTION CONTROL

1350	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051]. . . . . 12 CHILD CURATIVE CARE [Q1251] . . . . . 13 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY [Q1651]. . . . . 17 STI SERVICES [Q1851] . . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. . . . . 31 → **1353**

1351	**INFECTION CONTROL AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND COLOR CODED PLASTIC BIN LINER / LABELED BIN (RED, GREEN, YELLOW AND BLUE)	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT/ANTISEPTICS [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR AUTO-DISABLE SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13*	INJECTION SAFETY PRECAUTION GUIDELINES FOR STANDARD PRECAUTIONS (Surakchhit sui ko niti)	1	2	3
14*	NEEDLE DESTROYER	1	2	3
15*	METHYLATED SPIRIT AND GLYCIRINE 70:30	1	2	3

1352	DESCRIBE THE SETTING OF THE FP SERVICE ROOM OR AREA.	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4
1353	**CHECK Q212** FP COMMODITIES STORED IN OTHER LOCATION OR NOT STOCKED **(RESPONSE 1 NOT CIRCLED)**	FP COMMODITIES STORED IN FP SERVICE AREA **(RESPONSE 1 CIRCLED)** → 921

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 14: ANTENATAL CARE

1400	**CHECK Q102.05** ANC SERVICES AVAILABLE IN FACILITY ☐ ANC SERVICES NOT AVAILABLE IN FACILITY ☐ NEXT SECTION OR SERVICE SITE	

ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE ANTENATAL CARE SERVICES ARE PROVIDED.
FIND THE PERSON MOST KNOWLEDGEABLE ABOUT ANTENATAL CARE SERVICES IN THE FACILITY.
INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

1401	How many days in a month are antenatal care services offered at this facility? USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	NUMBER OF DAYS/MONTH ☐☐	
1401A	How many days in a month are ANC-specific outreach clinic conducted from this facility? USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	NUMBER OF DAYS/MONTH ☐☐	

1402*	Do ANC providers provide any of the following services to pregnant women as part of routine ANC?	YES	NO	
01	IRON SUPPLEMENTATION	1	2	
02	FOLIC ACID SUPPLEMENTATION	1	2	
04	TETANUS DIPTHERIA VACCINATION	1	2	
05*	ALBENDAZOLE	1	2	
06*	MISOPROSTOL	1	2	

1403*	**CHECK Q1402.04** Td VACCINATION PROVIDED ☐ Td VACCINATION NOT PROVIDED ☐ →		1406
1403A	How many days in a month is Td vaccination provided through outreach from this facility? USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	NUMBER OF DAYS/MONTH ☐☐	
1404*	Is tetanus diptheria vaccination available on all days that ANC services are available in this facility?	YES. . . . . 1 NOT ALL ANC DAYS. 2	→ 1406
1405*	How many days in a month are tetanus diptheria (Td) vaccination services available at this facility? USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	DAYS PER MONTH . . . . . ☐☐ LESS OFTEN THAN ONCE/MONTH. 00	

		(A) OBSERVED AVAILABLE		(B) NOT OBSERVED			
1406*	Do ANC providers in this facility provide any of the following **tests** from this site to pregnant women / clients as part of ANC? IF YES, ASK TO SEE THE TEST KIT OR EQUIPMENT. IF TEST NOT DONE IN ANC, PROBE TO DETERMINE IF THE TEST IS DONE ELSEWHERE IN THE FACILITY CHECK TO SEE IF AT LEAST ONE TEST KIT OF EACH TEST IS VALID/UNEXPIRED	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NONE AVAILABLE TODAY	NO, NEVER AVAILABLE	AVAILABLE ELSEWHERE IN FACILITY
02	URINE PROTEIN TEST	1	2	3	4	5	6
03	URINE GLUCOSE TEST	1	2	3	4	5	6
04*	HEMOGLOBIN TEST	1	2	3	4	5	6
05	SYPHILIS RAPID DIAGNOSTIC TEST	1	2	3	4	5	6
06*	BLOOD GLUCOSE TEST	1	2	3	4	5	6
07*	BLOOD GROUPING	1	2	3	4	5	6
08*	URINE PREGNANCY TEST	1	2	3	4	5	6

		(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
1406A*	Please tell me if any of the following HIV rapid diagnostic test (RDT) kits are available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NO, NEVER AVAILABLE
01	DETERMINE	1	2	3	4	5
02	UNIGOLD	1	2	3	4	5
03	STATPACK	1	2	3	4	5
04	TRIDOT	1	2	3	4	5
05	OTHER (SPECIFY) _____	1	2	3	4	5

1407*	As part of ANC services, please tell me if providers in this facility provide the following services to ANC clients	YES	NO
01	COUNSELING ON RECOMMENDED MINIMUM OF 4 ANC VISITS FOR EACH PREGNANCY	1	2
02	COUNSELING ON BIRTH PREPAREDNESS OR PREPARATION FOR DELIVERY	1	2
03	COUNSELING ABOUT FAMILY PLANNING	1	2
04	COUNSELING ABOUT HIV/AIDS	1	2
05*	COUNSELING ABOUT USE OF LLIN TO PREVENT MOSQUITO BITES AND MALARIA	1	2
06	COUNSELING ABOUT BREASTFEEDING	1	2
07	COUNSELING ABOUT NEWBORN CARE	1	2
08	COUNSELING ON POSTNATAL CARE VISITS	1	2

1408	Do ANC providers in this facility diagnose and treat suspected STIs, or are suspected STI clients referred to another provider or location for diagnosis and treatment?	DIAGNOSE AND TREAT STIs. . . . . 1 DIAGNOSE BUT REFER ELSEWHERE FOR TREATMENT 2 REFER ELSEWHERE IN FACILITY FOR DIAG & TREATM 3 REFER OUTSIDE FACILITY FOR DIAG & TREATMENT. . 4 NO DIAGNOSIS / TREATMENT / REFERRAL. 5	
1408A	Do ANC providers in this facility diagnose and treat suspected HIV, or are suspected HIV clients referred to another provider or location for diagnosis and treatment?	DIAGNOSE AND TREAT HIV. . . . . 1 DIAGNOSE BUT REFER ELSEWHERE FOR TREATMENT 2 REFER ELSEWHERE IN FACILITY FOR DIAG & TREATM 3 REFER OUTSIDE FACILITY FOR DIAG & TREATMENT. . 4 NO DIAGNOSIS / TREATMENT / REFERRAL. 5	
1409*	Do you have the RH clinical protocal for medical officers, staff nurses, ANM in this service area today?	YES. . . . . 1 NO. 2	→ 1411
1410*	May I see this guidelines? ACCEPTABLE IF PART OF OTHER GUIDELINES	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	→ 1415
1411*	Do you have ***any other ANC guidelines*** like Maternity guideline/National medical standard volume III in this service area today **(OTHERS)** ?	YES. . . . . 1 NO. 2	→ 1415
1412*	May I see these guidelines?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1415*	Do you have IEC/BCC materials like danger sign posters, BPB flip charts,ANC/PNC job aids, pamphlets for client education on subjects related to pregnancy or antenatal care available in this service area today?	YES. . . . . 1 NO. 2	→ 1417
1416	May I see the visual aids for client education?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1417*	Are any individual client cards or records for ANC and PNC clients maintained at this service site? (Maternal and Newborn Health Card (HMIS 3.5)) (Maternal and Newborn Health Service Register (HMIS 3.6)) (Any other client's health card)	YES. . . . . 1 NO. 2	→ 1419

1418	May I see a blank copy of the following client records, cards or registers?	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	Maternal and Newborn Health Card (HMIS 3.5)	1	2	3	
02*	Maternal and Newborn Health Service Register (HMIS 3.6)	1	2	3	
03	Any other client's health card	1	2	3	
1419	Does this facility have a system whereby observation or parameters for ANC clients are routinely carried out before the consultation? IF YES, ASK TO SEE THE PLACE WHERE THESE ACTIVITIES TAKE PLACE.	YES. . . . . 1 NO. 2			→ 1421

1420	OBSERVE IF THE BELOW ACTIVITIES ARE BEING DONE ROUTINELY. IF YOU DO NOT SEE AN ACTIVITY, ASK: Is [ACTIVITY YOU DO NOT SEE] routinely done for all antenatal care clients?	ACTIVITY OBSERVED	ACTIVITY REPORTED NOT SEEN	ACTIVITY NOT ROUTINELY DONE	DON'T KNOW
01	Weighing of clients	1	2	3	8
02	Taking blood pressure	1	2	3	8
03	Conducting group health education sessions	1	2	3	8
04	Urine test for protein	1	2	3	8
05	Blood test for anemia	1	2	3	8
06	Malaria rapid diagnostic testing	1	2	3	8
07	HIV testing and counseling (HTC) for pregnant women	1	2	3	8
08	Measuring client's height	1	2	3	8

EQUIPMENT AND SUPPLIES FOR ROUTINE ANC

1421*	I would like to know if the following items are available in this service area and are functioning.	(A) AVAILABLE			(B) FUNCTIONING		
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	DIGITAL BP APPARATUS	1 → b	2 → b	3 → 02	1	2	8
02	MANUAL BP APPARATUS	1 → b	2 → b	3 → 03	1	2	8
03	STETHOSCOPE	1 → b	2 → b	3 → 04	1	2	8
04	EXAMINATION LIGHT (FLASHLIGHT OK)	1 → b	2 → b	3 → 05	1	2	8
05*	FETAL STETHOSCOPE/PINARD (FETOSCOPE)	1 → b	2 → b	3 → 06	1	2	8
06	ADULT WEIGHING SCALE	1 → b	2 → b	3 → 07	1	2	8
07*	EXAMINATION BED/TABLE	1 → b	2 → b	3 → 08	1	2	8
08*	MEASURING TAPE FOR FUNDAL HEIGHT	1 → b	2 → b	3 → 09	1	2	8
09*	THERMOMETER	1 → b	2 → b	3 → 1422	1	2	8

1422*	Please tell me if any of the following medicines / items are available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NO, OR NEVER AVAILABLE
01	IRON TABLETS (INDIVIDUAL TABLETS)	1	2	3	4	5
02	FOLIC ACID TABLETS (INDIVIDUAL TABLETS)	1	2	3	4	5
03	COMBINED IRON AND FOLIC ACID TABLETS	1	2	3	4	5
05	TETANUS DIPTHERIA TOXOID VACCINE	1	2	3	4	5
06*	LONG LASTING INSECTICIDE TREATED NETS (LLINs)	1	2	3	4	5
07*	ALBENDAZOLE	1	2	3	4	5

INFECTION CONTROL

1450	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051]. . . . . 12 CHILD CURATIVE CARE [Q1251] . . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 PMTCT [Q1551]. . . . . 16 DELIVERY [Q1651]. . . . . 17 STI SERVICES [Q1851] . . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. . . . . 31 → NEXT SECTION / SERVICE SITE

1451	**INFECTION CONTROL AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND COLOR CODED PLASTIC BIN LINER / LABELED BIN (RED, GREEN, YELLOW AND BLUE)	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT/ANTISEPTICS [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE-USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR AUTO-DISABLE SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13*	INJECTION SAFETY PRECAUTION GUIDELINES FOR STANDARD PRECAUTIONS (Surakchhit sui ko niti)	1	2	3
14*	NEEDLE DESTROYER	1	2	3
15*	METHYLATED SPIRIT AND GLYCIRINE 70:30	1	2	3

1452*	DESCRIBE THE SETTING OF THE ANC SERVICE ROOM OR AREA.	PRIVATE SEPARATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRI 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 15: PMTCT OF HIV INFECTION

1500	**CHECK Q102.06** PMTCT SERVICES OFFERED IN FACILITY ☐ → NO PMTCT SERVICES IN FACILITY ☐ → NEXT SECTION OR SERVICE SITE	

CAUTION!!!

THIS SECTION SHOULD BE COMPLETED ONLY AFTER COMPLETING THE ANC SECTION

ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE PMTCT SERVICES ARE PROVIDED.
FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF PMTCT SERVICES IN THE FACILITY.
INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

	As part of PMTCT services, please tell me if providers in this facility provide the following services to clients	YES	NO
01	PROVIDE HIV COUNSELING AND TESTING SERVICES TO PREGNANT WOMEN. THIS ALSO INCLUDES TESTING DONE OUTSIDE THIS LOCATION BUT RESULTS PROVIDED TO CLIENT HERE	1	2
02	PROVIDE HIV TESTING SERVICES TO INFANTS BORN TO HIV POSITIVE WOMEN. THIS ALSO INCLUDES TESTING DONE OUTSIDE THIS LOCATION BUT RESULTS PROVIDED TO CLIENT HERE. FOR EXAMPLE, BLOOD COLLECTED HERE AS DBS BUT TESTING DONE ELSEWHERE	1	2
03	PROVIDE ARV PROPHYLAXIS TO HIV POSITIVE PREGNANT WOMEN	1	2
04	PROVIDE ARV PROPHYLAXIS TO NEWBORNS OF HIV POSITIVE WOMEN	1	2
05	PROVIDE INFANT AND YOUNG CHILD FEEDING COUNSELING FOR PMTCT (INCLUDING EXCLUSIVE BREAST FEEDING COUNSELING FOR PMTCT)	1	2
06	PROVIDE NUTRITIONAL COUNSELING FOR HIV POSITIVE PREGNANT WOMEN AND THEIR INFANTS	1	2
07	PROVIDE FAMILY PLANNING COUNSELING TO HIV POSITIVE PREGNANT WOMEN	1	2

1502	**CHECK Q1501.01** HIV COUNSELING AND TESTING FOR PREGNANT WOMEN ☐ → NO HIV TESTING FOR PREGNANT WOMEN, ONLY HIV COUNSELING FOR PREGNANT WOMEN ☐	→ 1506	
1503	IS THIS THE SAME LOCATION AS THE ANC SERVICE SITE?	YES, ANC SERVICE SITE. . . . . 1 NO, DIFFERENT LOCATION. 2	→ 1506
1504	Is HIV rapid diagnostic testing available from this service site?	YES. . . . . 1 NO. 2	→ 1506

	Please tell me if any of the following HIV rapid diagnostic test (RDT) kits are available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NO, NEVER AVAILABLE
01	DETERMINE	1	2	3	4	5
02	UNIGOLD	1	2	3	4	5
03	STATPACK	1	2	3	4	5
04	TRIDOT	1	2	3	4	5
05	OTHER (SPECIFY) _____	1	2	3	4	5

1506	**CHECK Q1501.02** INFANT HIV COUNSELING AND TESTING ☐ → NO INFANT HIV TESTING ONLY INFANT HIV COUNSELING ☐	→ 1509	
1507*	Do you use DBS card/paper to collect dried blood spots (DBS) at this site ?	YES. . . . . 1 NO. 2	→ 1509
1508*	May I see sample DBS paper/ cards? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NOT AVAILABLE TODAY. 4	
1508A	Are the DBS samples collected at this site for External Quality Assurance (EQUAS) purposes?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	

1509*	Do you have the ***national guidelines*** for PMTCT available in this service area?	YES. . . . . 1 NO. 2	→ 1515
1510*	May I see the national PMTCT guidelines?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1515	Do you stock any ARVs for PMTCT in this service area?	YES. . . . . 1 NO. 2	→ 1550

		(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
1516*	Please tell me if any of the following antiretroviral medicines/drugs are available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NO, OR NEVER AVAILABLE
01	ZIDOVUDINE (AZT) TABS	1	2	3	4	5
02	NEVIRAPINE (NVP) TABS	1	2	3	4	5
03	LAMIVUDINE (3TC) TABS	1	2	3	4	5
04	LOPINAVIR (LPV/r) TABS	1	2	3	4	5
05	ABACAVIR (ABC) TABS	1	2	3	4	5
06	EFAVIRENZ (EFV) TABS	1	2	3	4	5
07	TENAFOVIR DISOPROXIL FUMARATE (TDF) TABS	1	2	3	4	5
09	ZIDOVUDINE (ZDV) + LAMIVUDINE (3TC)	1	2	3	4	5
10	NEVIRAPINE (NVP) SYRUP	1	2	3	4	5
11	ZIDOVUDINE (AZT) SYRUP OR DISPERSIBLE PEDIATRIC TABS	1	2	3	4	5
12	LAMIVUDINE (3TC) + EFAVIRENZ (EFV) + TENAFOVIR (TDF)	1	2	3	4	5
13*	ZIDOVUDINE (AZT, ZDV) + 3TC + NVP	1	2	3	4	5
14*	3TC + EFV	1	2	3	4	5

INFECTION CONTROL

1550	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051] . . . . . 12 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 DELIVERY [Q1651]. . . . . 17 STI SERVICES [Q1851] . . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. . . . . 31 → NEXT SECTION / SERVICE SITE

1551*	**INFECTION CONTROL AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04*	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND COLOR CODED PLASTIC BIN LINER / LABELED BIN (RED, GREEN, YELLOW AND BLUE)	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT/ANTISEPTICS [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE-USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR AUTO-DISABLE SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13*	INJECTION SAFETY PRECAUTION GUIDELINES FOR STANDARD PRECAUTIONS (Surakchhit sui ko niti)	1	2	3
14*	NEEDLE DESTROYER	1	2	3
15*	METHYLATED SPIRIT AND GLYCIRINE 70:30	1	2	3

1552	ASK TO SEE ROOM OR AREA WHERE PMTCT SERVICES ARE PROVIDED DESCRIBE THE SETTING OF THE ROOM OR AREA.	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4

1552A	**CHECK Q216**		
	ARV MEDICINES FOR ART STORED IN OTHER LOCATION OR NOT STOCKED **(RESPONSE 4 OR 5 NOT CIRCLED)** →	ARV MEDICINES FOR ART STORED IN PMTCT SERVICE AREA **(RESPONSE 4 OR 5 CIRCLED)** →	941

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 16: DELIVERY AND NEWBORN CARE

1600	**CHECK Q102.07** NORMAL DELIVERY AVAILABLE ↓ NORMAL DELIVERY NOT AVAILABLE → NEXT SECTION OR SERVICE SITE		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE NORMAL DELIVERY SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT DELIVERY SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
1601	Is a person skilled in conducting deliveries present at the facility today or on call at all times (24 hours a day), including weekends, to provide care? Specifically, I am referring to medical specialists, medical officers, assistant medical officers, clinical officers, assistant clinical officers, registered nurses and enrolled nurses.	YES . . . . . 1 NO. 2	→ 1604
1602	Is there a duty schedule or call list for 24-hr staff assignment?	YES . . . . . 1 NO. 2	→ 1604
1603	May I see the duty schedule or call list for 24-HR staff assignment?	OBSERVED . . . . . 1 REPORTED, NOT SEEN. 2	

SIGNAL FUNCTIONS

1604*	Please tell me if any of the following interventions have ever been carried out by providers as part of their work in this facility, and if so, whether the intervention has been carried out at least once during the past 3 months.	(A) EVER PROVIDED IN FACILITY YES	NO	DK	(B) PROVIDED IN PAST 3 MONTHS YES	NO	DK
01	PARENTERAL ADMINISTRATION OF ANTIBIOTICS (IV OR IM)	1 → b	2 → 02	8 → 02	1	2	8
02	PARENTERAL ADMINISTRATION OF OXYTOCIC (IV OR IM)	1 → b	2 → 03	8 → 03	1	2	8
03	PARENTERAL ADMINISTRATION OF ANTICONVULSANT FOR HYPERTENSIVE DISORDERS OF PREGNANCY (IV OR IM)	1 → b	2 → 04	8 → 04	1	2	8
04	ASSISTED VAGINAL DELIVERY	1 → b	2 → 05	8 → 05	1	2	8
05	MANUAL REMOVAL OF PLACENTA	1 → b	2 → 06	8 → 06	1	2	8
06	REMOVAL OF RETAINED PRODUCTS OF CONCEPTAION	1 → b	2 → 07	8 → 07	1	2	8
07	NEONATAL RESUSCITATION	1 → b	2 → 08	8 → 08	1	2	8
08*	CORTICOSTEROIDS FOR PRE-TERM LABOR **NOTE: THIS IS NOT A SIGNAL FUNCTION**	1 → b	2 → 09	8 → 09	1	2	8
09	COMPREHENSIVE ABORTION CARE (CAC) BY MVA **NOT A SIGNAL FUNCTION APPLICABLE IN PHC AND ABOVE, I.E., FACILITY TYPES 1, 2, 3, 4, 5, 6, 7 and 12**	1 → b	2 → 10	8 → 10	1	2	8
10	MEDICAL ABORTION **NOT A SIGNAL FUNCTION APPLICABLE IN HP AND ABOVE, I.E., FACILITY TYPES 1, 2, 3, 4, 5, 6, 7, 8 and 12**	1 → b	2 → 1605	8 → 1605	1	2	8

1605*	Do you have the national medical standard Volume III guidelines available in this service site? (NMH VOL III)	YES. . . . . 1 NO. 2	→ 1607
1606*	May I see the NMH Vol III?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1607*	Do you have the RH clinical guidelines?	YES. . . . . 1 NO. 2	→ 1611
1608*	May I see the RH clinical guidelines?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1611	Does this facility practice Kangaroo Mother Care for low birth weight babies?	YES. . . . . 1 NO. 2	→ 1613
1612	Is there a separate room or space for Kangaroo Mother Care or is it integrated into the main postnatal ward?	YES, SEPARATE ROOM. . . . . 1 NO, INTEGRATED 2	

1613	Do providers of delivery services in this facility use partograph to monitor labor and delivery?	YES. . . . . 1 NO USE OF PARTOGRAPH. 2	→ 1615
1614	Are partographs used routinely (for all cases) or selectively (only for some cases) to monitor labor and delivery in this facility?	ROUTINELY. . . . . 1 SELECTIVELY. 2	
1615*	How many dedicated functional maternity beds are available in this facility?	# OF DEDICATED MATERNITY BEDS. . . . ☐☐☐ DON'T KNOW 998	
1616*	How many functional dedicated delivery beds are available in this facility?	# OF DEDICATED DELIVERY BEDS. . . . ☐☐☐ DON'T KNOW. 998	
1617*	Does the facility conduct regular reviews of maternal or newborn deaths?	YES. . . . . 1 NO, DOES NOT PARTICIPATE. 2	→ 1622
1617A	May I see the maternal/new born death form?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1618	Are reviews done for mothers only, newborns only, or for both mothers and newborns?	FOR MOTHERS ONLY. . . . . 1 FOR NEWBORNS ONLY. . . . . 2 FOR BOTH MOTHERS AND NEWBORNS. . . . 3	→ 1621
1619*	How often are reviews of <u>maternal deaths done</u>? USE A 4-WEEK MONTH IF NEEDED	EVERY: ☐☐ WEEKS ONLY WHEN CASE OCCURS. . . . . 53 DON'T KNOW. 98	→ 1620 → 1620
1619A*	Following a maternal death, how much time elapses before a maternal death review is done?	WITHIN 72 HOURS. . . . . 1 AFTER 72 HOURS. . . . . 2 VARIES FROM CASE TO CASE. . . . . 3 DON'T KNOW. 8	
1620	**CHECK Q1618:** RESPONSES "2" OR "3" CIRCLED ☐ RESPONSES "2" OR "3" NOT CIRCLED ☐		→ 1622
1621*	How often are reviews of <u>perinatal deaths done</u>? USE A 4-WEEK MONTH IF NEEDED	EVERY: ☐☐ WEEKS ONLY WHEN CASE OCCURS. . . . . 53 ALWAYS WITH MATERNAL REVIEWS. . . . 95 DON'T KNOW. 98	

EQUIPMENT AND SUPPLIES FOR ROUTINE DELIVERIES

		(A) AVAILABLE			(B) FUNCTIONING		
1622*	I would like to know if the following items are available in this delivery area and are functioning.	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	INCUBATOR	1 → b	2 → b	3 → 02	1	2	8
02	OTHER EXTERNAL HEAT SOURCE	1 → b	2 → b	3 → 03	1	2	8
03	EXAMINATION LIGHT (FLASHLIGHT OK)	1 → b	2 → b	3 → 04	1	2	8
04	SUCTION APPARATUS WITH CATHETER	1 → b	2 → b	3 → 05	1	2	8
05*	DELEE'S SUCTION TUBE	1 → b	2 → b	3 → 06	1	2	8
06	VACUUM EXTRACTOR (FOR VACUUM-ASSISTED DELIVERY)	1 → b	2 → b	3 → 07	1	2	8
07	VACUUM ASPIRATION KIT OR MVA KITS	1 → b	2 → b	3 → 08	1	2	8
08	NEWBORN BAG & MASK (AMBU BAG & MASK)	1 → b	2 → b	3 → 09	1	2	8
09	THERMOMETER	1 → b	2 → b	3 → 11	1	2	8
11	INFANT WEIGHING SCALE	1 → b	2 → b	3 → 12	1	2	8
12*	FETAL STETHOSCOPE/PINARD (FETOSCOPE)	1 → b	2 → b	3 → 13	1	2	8
13	DIGITAL BLOOD PRESSURE APPARATUS	1 → b	2 → b	3 → 14	1	2	8
14	MANUAL BLOOD PRESSURE MACHINE	1 → b	2 → b	3 → 15	1	2	8
15	STETHOSCOPE	1 → b	2 → b	3 → 1623	1	2	8

1623*	Do you have any of the following items? If yes, I would like to see them	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE
01	DELIVERY BED	1	2	3
02	DELIVERY SET/KIT	1	2	3
03	CORD CLAMP	1	2	3
04	SPECULUM	1	2	3
05	EPISIOTOMY SCISSORS	1	2	3
06	SCISSORS OR BLADE TO CUT CORD	1	2	3
07	SUTURE MATERIAL WITH NEEDLE	1	2	3
08	NEEDLE HOLDER	1	2	3
09	FORCEPS (LARGE)	1	2	3
10	FORCEPS (MEDIUM)	1	2	3
11	SPONGE HOLDER	1	2	3
12	BLANK PARTOGRAPH	1	2	3
13	WRAPPER (4 PIECES)	1	2	3
14*	NYANO JHOLA (WARM BAG)	1	2	3

1624*	Does this facility ***routinely*** observe any of the following postpartum or newborns related practices?	YES	NO	DON'T KNOW
01	Delivery to the abdomen (Skin to Skin)	1	2	8
02	Drying and wrapping newborns to keep them warm	1	2	8
03	Initiation of breastfeeding within the first hour	1	2	8
04	Routine, complete (head-to-toe) examination of newborn before discharge	1	2	8
05	Suction of the newborn by means of catheter	1	2	8
06*	Suction of the newborn by means of delees suction	1	2	8
07	Weigh the newborn immediately	1	2	8
08	Administer Vitamin K to newborn	1	2	8
09	Apply tetracycline ointment to both eyes	1	2	8
13	Give the newborn BCG prior to discharge	1	2	8
14*	Apply Chlorexidine ointment to umbilical stump.	1	2	8
15*	Delay full bath after 24hours of birth	1	2	8
16*	Administer Vitamin K to preterm babies	1	2	8

		(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
1625*	Please tell me if any of the following medicines or items are available at this service site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NO, OR NEVER AVAILABLE
01	TETRACYCLINE EYE OINTMENT FOR NEWBORN	1	2	3	4	5
02	INJECTABLE ANTIBIOTIC (E.G., CEFTRIAXONE, AMPICILLIN)	1	2	3	4	5
03	INJECTABLE UTEROTONIC (E.G., OXYTOCIN)	1	2	3	4	5
04	MAGNESIUM SULPHATE	1	2	3	4	5
05	INJECTABLE DIAZEPAM	1	2	3	4	5
06	IV SOLUTION (RINGER LACTATE) WITH INFUSION SET	1	2	3	4	5
07	SKIN DISINFECTANT (OTHER THAN CHLORHEXIDINE, eg. BETADINE)	1	2	3	4	5
08*	7.1% CHORHEXIDINE OINTMENT (UMBILICAL CORD CLEANSING)	1	2	3	4	5
09	HYDRALAZINE INJECTION	1	2	3	4	5
10*	NIFEDIPINE CAPSULE	1	2	3	4	5
11*	AVAILABILITY OF MOTHER'S MILK SUBSTITUTE	1	2	3	4	5
12*	CALCIUM GLUCONATE	1	2	3	4	5

1625A*	Does this facility have any system for ordering and receiving drugs related to emergency obstetric care (EOC) for this faciltity? [Including: Magnesium sulphate inj, Oxytocin inj, calcium gluconate, dextrose, anti-hypertensive drug (nifedipine), ringer lactate inj]	YES. . . . . 1 NO 2	→ 1626
1625B*	On average approximately how long does it take between ordering and receiving drugs related to emergency obstetric care (EOC) for this faciltity?	< 2 WEEKS . . . . . 1 ≥ 2 WEEKS BUT NOT UP TO ONE MON 2 ≥ 1 MONTH BUT NOT UP TO 2 MONTH: 3 ≥ 2 MONTH BUT NOT UP TO 4 MONTH: 4 ≥ 4 MONTH BUT NOT UP TO 6 MONTH: 5	

PMTCT DURING LABOR AND DELIVERY

1625C	**CHECK Q102.06** PMTCT SERVICES OFFERED IN FACILITY ☐				NO PMTCT SERVICES IN FACILITY ☐ Q 1650		
1626	Do you provide or offer any PMTCT service at this service site for women who come in to deliver?				YES. . . . . 1 NO. 2		
1627	Do providers of delivery services conduct HIV testing from this service site?				YES. . . . . 1 NO. 2		→ 1629
1628*	Please tell me if any of the following HIV rapid diagnostic test (RDT) kits are available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED			
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NO, NEVER AVAILABLE	
01	DETERMINE	1	2	3	4	5	
02	UNIGOLD	1	2	3	4	5	
03	STATPACK	1	2	3	4	5	
04	TRIDOT	1	2	3	4	5	
05	OTHER (SPECIFY) _____	1	2	3	4	5	
1629	Do you stock any ARVs for PMTCT in this service area?				YES. . . . . 1 NO. 2		→ 1650
1630	Please tell me if any of the following antiretroviral medicines for PMTCT are available at this service site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED			
		AT LEAST ONE VALID	AVAILABLE NON VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NO, NEVER AVAILABLE	
01	ZIDOVUDINE (AZT) TABS	1	2	3	4	5	
02	NEVIRAPINE (NVP) TABS	1	2	3	4	5	
03	LAMIVUDINE (3TC) TABS	1	2	3	4	5	
04	LOPINAVIR (LPV/r) TABS	1	2	3	4	5	
05	ABACAVIR (ABC) TABS	1	2	3	4	5	
06	EFAVIRENZ (EFV) TABS	1	2	3	4	5	
07	TENAFOVIR DISOPROXIL FUMARATE (TDF) TABS	1	2	3	4	5	
09	ZIDOVUDINE (ZDV) + LAMIVUDINE (3TC)	1	2	3	4	5	
10	NEVIRAPINE (NVP) SYRUP	1	2	3	4	5	
11	ZIDOVUDINE (AZT) SYRUP	1	2	3	4	5	
12	LAMIVUDINE (3TC) + EFAVIRENZ (EFV) + TENAFOVIR (TDF)	1	2	3	4	5	
13*	ZIDOVUDINE (AZT, ZDV) + 3TC + NVP	1	2	3	4	5	
14*	3TC + EFV	1	2	3	4	5	

INFECTION CONTROL

1650	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051] . . . . . 12 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 STI SERVICES [Q1851] . . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. . . . . 31 → NEXT SECTION / SERVICE SITE

1651*	**INFECTION CONTROL AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04*	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND COLOR CODED PLASTIC BIN LINER / LABELED BIN (RED, GREEN, YELLOW AND BLUE)	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT/ANTISEPTICS [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE-USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR AUTO-DISABLE SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13*	INJECTION SAFETY PRECAUTION GUIDELINES FOR STANDARD PRECAUTIONS (Surakchhit sui ko niti)	1	2	3
14*	NEEDLE DESTROYER	1	2	3
15*	METHYLATED SPIRIT AND GLYCIRINE 70:30	1	2	3

1652	DESCRIBE THE SETTING OF THE DELIVERY SERVICE ROOM OR AREA.	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 17: MALARIA

1700	**CHECK Q102.08:** MALARIA SERVICES AVAILABLE ☐	NO MALARIA SERVICES ☐ NEXT SECTION OR SERVICE SITE	

ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE CLIENTS WITH MALARIA ARE SEEN.
FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF MALARIA SERVICES IN THE FACILITY.
INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

1701	How many days in a month are malaria services available in this facility? [USE A 4-WEEK MONTH TO CALCULATE DAYS]	DAYS/MONTH. . . . . ☐☐	
1702	Do providers in this facility diagnose malaria?	YES . . . . . 1 NO 2	→ 1710
1703	Do providers in this facility use blood tests to verify the diagnosis of malaria, either by microscopy or mRDT?	YES. . . . . 1 NO 2	→ 1710
1704	Do providers use blood test to verify the diagnosis of malaria for all suspected cases (always), or only sometimes?	ALWAYS. . . . . 1 ONLY SOMETIMES. 2	
1705	Do providers use malaria rapid diagnostic test (mRDT) to diagnose malaria at this service site?	YES . . . . . 1 NO 2	→ 1710
1706	May I see a sample malaria RDT kit? CHECK THAT AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	
1708	Do you have a training manual, poster or other job aid for using malaria rapid diagnostic test?	YES . . . . . 1 NO 2	→ 1710
1709	May I see the training manual, poster or other job aid for using malaria rapid diagnostic test?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
1710	Do providers in this facility prescribe treatment for uncomplicated malaria?	YES . . . . . 1 NO 2	
1710A	**CHECK Q1702 AND Q1710** RESPONSE "1" CIRCLED IN EITHER Q1702 OR Q1710 ☐	RESPONSE "1" NOT CIRCLED IN EITHER Q1702 OR Q1710 ☐ NEXT SECTION OR SERVICE SITE	
1711*	Do you have the ***national treatement wallchart for malaria*** available in this service area? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO 2	→ 1712A
1712*	May I see this national guidelines for the diagnosis and treatment of malaria?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. . . . . 2 NEXT SECTION OR SERVICE SITE	
1712A	Do you have the ***national clinical protocol for malaria*** available in this service area?	YES . . . . . 1 NO . . . . . 2 NEXT SECTION OR SERVICE SITE	
1712B	May I see the national clinical protocol for malaria?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

SECTION 17A: KALAAZAR / LEISHMANIASIS

1720A	**CHECK Q102.20:** KALAAZAR/LEISHMANIASIS SERVICES AVAILABLE ☐ NO KALAAZAR/LEISHMANIASIS SERVICES ☐ NEXT SECTION OR SERVICE SITE ←		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE CLIENTS WITH KALAAZAR/LEISHMANIASIS ARE SEEN. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF KALAAZAR/LEISHMANIASIS SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
1720B	Do providers in this facility diagnose kalaazar / Leishmaniasis using RDT (RK-39) at this service site?	YES . . . . . 1 NO 2	→ 1720D
1720C	May I see a sample of kalaazar / Leishmaniasis RDT (RK-39) kit? CHECK THAT AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	
1720D	Do providers in this facility provide treatment of kalaazar / Leishmaniasis ?	YES . . . . . 1 NO . . . . . 2 NEXT SECTION OR SERVICE SITE ←	
1720E	Do you have the ***national protocal for diagnosis and*** treatment of ***kalaazar / Leishmaniasis*** available in this service area?	YES . . . . . 1 NO . . . . . 2 NEXT SECTION OR SERVICE SITE ←	
1720F	May I see this protocal?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

SECTION 17B: SNAKE BITE

1730A	**CHECK Q102.21:** SNAKEBITE SERVICES AVAILABLE ☐ NO SNAKEBITE SERVICES ☐ NEXT SECTION OR SERVICE SITE ←		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE CLIENTS WITH SNAKE BITE ARE SEEN. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF SNAKE BITE SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
1730B	Does this facility provide first aid management of snake bite?	YES . . . . . 1 NO 2	→ 1730E
1730C	Do you have the national protocal for management of snakebite? (i.e. The snake biting management guide book) OBSERVE	OBSERVED. . . . . 1 REPORTED NOT SEEN . . . . . 2 NOT AVAILABLE 3	
1730D	Is ASV (anti snake venom) avaibale in this facility? OBSERVE	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NOT AVAILABLE. . . . . 4 NEXT SECTION OR SERVICE SITE ←	
1730E	What is the distance in kilometer from this facility to the nearest referral facility for manageming and treating snake bites?	DISTANCE TO REFERRAL CENTER Km ☐☐☐	

SECTION 17C: DOG BITE/RABIES

1740A	**CHECK Q102.22:** DOGBITE/RABIES SERVICES AVAILABLE ☐ NO DOGBITE/RABIES SERVICES ☐ NEXT SECTION OR SERVICE SITE ←		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE CLIENTS WITH DOG BITE/RABIES ARE SEEN. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF DOG BITE/RABIES SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
1740B	Does this facility provide first aid management of dog bite/rabies?	YES . . . . . 1 NO 2	→ 1740E
1740C	Do you have national protocal for management of dog bite/rabies? OBSERVE	OBSERVED. . . . . 1 REPORTED NOT SEEN . . . . . 2 NOT AVAILABLE 3	
1740D	Is ARV (anti rabies vaccine) avaibale in this facility? OBSERVE	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NOT AVAILABLE. . . . . 4 NEXT SECTION OR SERVICE SITE ←	
1740E	What is the distance in kilometer from this facility to the nearest referral facility for manageming and treating dog bites / Rabies?	DISTANCE TO REFERRAL CENTER Km ☐☐☐	
	THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.		

SECTION 18: SEXUALLY TRANSMITTED INFECTIONS

1800	**CHECK Q102.09** STI SERVICE OFFERED ☐ →	STI SERVICE NOT OFFERED ☐ → NEXT SECTION OR SERVICE SITE	
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE STI SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF STI SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
1801	How many days in a month are STI services available in this facility? [USE A 4-WEEK MONTH TO CALCULATE DAYS]	DAYS/MONTH . . . . . ☐☐	
1802	Do providers in this facility make diagnosis that a client has a sexually transmitted infection (STI)?	YES. . . . . 1 NO. 2	→ 1804
1803*	How are diagnoses of STIs made in this facility?	SYNDROMIC APPROACH ONLY. . . . . 1 ETIOLOGIC (LAB) ONLY. . . . . 2 BOTH SYNDROMIC AND ETIOLOGIC. . . . . 3 CLINICAL DIAGNOSIS ONLY. . . . . 4 BOTH CLINICAL DIAGNOSIS AND ETIOLOGIC. 5	
1804	Do providers in this facility prescribe treatment for STIs?	YES. . . . . 1 NO 2	
1805	**CHECK Q1802 AND Q1804** RESPONSE "1" CIRCLED IN EITHER Q1802 OR Q1804 OR BOTH ☐ →	RESPONSE "1" CIRCLED IN NEITHER Q1802 NOR Q1804 ☐ → NEXT SECTION OR SERVICE SITE	
1806	Are STI clients seen by this service ever referred for HIV counseling and testing, or offered the service from this service site?	YES. . . . . 1 NO 2	→ 1810
1807	Are STI clients seen by this service routinely referred for, or offered HIV counseling and testing, or they are referred / offered only if they are suspected to be infected with HIV?	ROUTINELY REFERRED OR OFFERED SERVICE. . . . . 1 ONLY IF CLIENT SUSPECTED TO BE HIV INFECTED. . . . 2	
1808	Do STI service providers in this facility provide HIV testing from this service site?	YES. . . . . 1 NO 2	→ 1810

1809*	Please tell me if any of the following HIV rapid diagnostic test (RDT) kits are available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NO, NEVER AVAILABLE
01	DETERMINE	1	2	3	4	5
02	UNIGOLD	1	2	3	4	5
03	STATPACK	1	2	3	4	5
04	TRIDOT	1	2	3	4	5
05	OTHER (SPECIFY) _____	1	2	3	4	5

1810*	Do you have the ***national guidelines*** on case management of sexually transmitted infections available in this service area? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO 2	→ 1814
1811*	May I see the national guidelines on case management of sexually transmitted infections ?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1814	Does the facility normally perform partner notification for sexually transmitted infections?	YES. . . . . 1 NO PARTNER NOTIFICATION. 2	→ 1816
1815	Is the notification ever active (where the facility makes contact with the partner) or is it only passive (where the facility asks the clients to inform or bring their partners)?	ALWAYS ACTIVE . . . . . 1 SOMETIMES ACTIVE. . . . . 2 ONLY PASSIVE. 3	
1816*	Are individual client health register or booklets maintained ?	YES. . . . . 1 NO. 2	→ 1818
1817*	May I see a copy of this register ?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	

1818*	ASK TO SEE EACH OF THE FOLLOWING ITEMS, AND ASSESS IF THE ITEM IS IN THE ROOM WHERE COUNSELING OR EXAMINATION OF STI CLIENTS TAKES PLACE OR AN IMMEDIATELY ADJACENT ROOM.				
	VISUAL AIDS FOR TEACHING CLIENT:	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	About STIs	1	2	3	8
02	About HIV/AIDS	1	2	3	8
03	About cervical cancer	1	2	3	8
04	Posters on STIs (MAY INCLUDE HIV/AIDS)	1	2	3	8
05	Posters on HIV/AIDS	1	2	3	8
06*	Model to demonstrate use of male condom (DILDO)	1	2	3	8
	ITEMS / INFORMATION FOR CLIENT TO TAKE HOME				
08	About STIs	1	2	3	8
09	About HIV/AIDS	1	2	3	8
10	About cervical cancer	1	2	3	8
11	IEC materials on male condoms	1	2	3	8
13	Male condoms that can be given to the client	1	2	3	8

INFECTION CONTROL

1850	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051] . . . . . 12 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY SERVICES [Q1651]. . . . . 17 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. 31	NEXT SECTION / SERVICE SITE

1851	**INFECTION CONTROL AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND COLOR CODED PLASTIC BIN LINER / LABELED BIN (RED, GREEN, YELLOW AND BLUE)	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT/ANTISEPTICS [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE USE STANDARD DISPOSABLE SYRINGES AND NEEDLES OR AUTO-DISABLE SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13*	INJECTION SAFETY PRECAUTION GUIDELINES FOR STANDARD PRECAUTIONS (Surakchhit sui ko niti)	1	2	3
14*	NEEDLE DESTROYER	1	2	3
15*	METHYLATED SPIRIT AND GLYCIRINE 70:30	1	2	3

1852	DESCRIBE THE SETTING OF THE ROOM OR AREA	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4	

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 19: TUBERCULOSIS

1900	**CHECK Q102.10** TB SERVICES OFFERED IN FACILITY ☐ NO TB SERVICES IN FACILITY ☐ → NEXT SECTION OR SERVICE SITE		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE TB SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF TB SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
1901	How many days in a month are tuberculosis services offered at this facility? USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	NUMBER OF DAYS / MONTH ☐☐	

TB DIAGNOSIS

1902	Do providers in this facility make diagnosis that a client has tuberculosis?	YES. . . . . 1 NO 2	→ 1904
1903*	What is the most common method used by providers in this facility for diagnosing TB? PROBE TO DETERMINE METHOD USED.	SPUTUM SMEAR ONLY. . . . . 1 X-RAY ONLY. . . . . 2 EITHER SPUTUM OR X-RAY. . . . . 3 BOTH SPUTUM AND X-RAY. . . . . 4 CLINICAL SYMPTOMS ONLY. . . . . 5 GENE XPERT. . . . . 6 ALL 3: SPUTUM + X-RAY + GENE XPERT. 7	
1904	Do providers in this facility ever refer clients outside this facility for TB diagnosis?	YES. . . . . 1 NO 2	→ 1908
1905	Does this facility have an agreement with a referral site for TB test results to be returned to the facility either directly or through the client?	YES. . . . . 1 NO. 2	
1906	Is there a record/register of clients who are referred for TB diagnosis?	YES . . . . . 1 REGISTER NOT KEPT. 2	→ 1908
1907*	May I see the records or register of clients referred for TB testing? CHECK THE RECORDS TO SEE TB DIAGNOSIS RESULTS ARE RECORDED	REGISTER SEEN (PAPER) . . . . . 1 REGISTER SEEN (ELECTRONIC). . . . . 2 REGISTER REPORTED, NOT SEEN. . . . . 3 REGISTER SEEN (BOTH PAPER AND ELECTRON 4	

TB TREATMENT

1908	Do providers in this facility prescribe treatment for TB or manage patients who are on TB treatment?	YES. . . . . 1 NO. 2	→ 1910
1909*	What treatment **regimen** is followed by providers in this facility for *newly diagnosed Pulmonary TB*? i.e., for new patients, not for retreatment? PROBE TO ARRIVE AT CORRECT RESPONSE	2M INTENSIVE PHASE, 4M CONTINUATION PHASE. . . . . 1 3M INTENSIVE PHASE,4M CONTINUATION PHASE. . . . . 2 OTHER _____ 6 SPECIFY	
1909A	What treatment **approach** is followed by providers in this facility for *newly diagnosed Pulmonary TB*? i.e., for new patients, not for retreatment? PROBE TO ARRIVE AT CORRECT RESPONSE	FOLLOW UP CLIENTS ONLY AFTER FIRST 2M INTENSIVE PHASE ELSEWHERE. . . . . 01 DIAGNOSE AND TREAT WHILE INPATIENT DISCHARGE ELSEWHERE FOR F/UP. . . . . 02 PROVIDE FULL TREATMENT, WITH NO ROUTINE DIRECT OBSERVATION PHASE. . . . . 03 DIAGNOSE, PRESCRIBE/PROVIDE MEDICINES ONLY, NO F/UP. . . . . 04 DIAGNOSE ONLY, NO TREATMENT OR PRESCRIPTION OF MEDICINE. . . . . 05 PROVIDE FULL TREATMENT, WITH ROUTINE DIRECT OBSERVATION PHASE. . . . . 07 OTHER_____ 06 (SPECIFY)	

1910	**CHECK Q1902 AND Q1908** TB DIAGNOSIS OR TREATMENT IN FACILITY ☐ NO TB DIAGNOSIS OR TREATMENT IN FACILITY ☐ → NEXT SECTION OR SERVICE SITE		
1911	Does this facility have a system for testing TB patients for HIV infection?	YES. . . . . 1 NO SYSTEM. 2	→ 1913
1912	May I see the system, or evidence of such a system? THE SYSTEM MAY BE IN THE FORM OF A REGISTER	SYSTEM OR REGISTER OBSERVED. . . . . 1 SYSTEM OR REGISTER REPORTED, NOT SEEN. 2	
1913	Is HIV rapid diagnostic testing available from this service site?	YES. . . . . 1 NO 2	→ 1915

1914*	Please tell me if any of the following HIV rapid diagnostic test (RDT) kits are available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NO, NEVER AVAILABLE
01	DETERMINE	1	2	3	4	5
02	UNIGOLD	1	2	3	4	5
03	STATPACK	1	2	3	4	5
04	TRIDOT	1	2	3	4	5
05	OTHER (SPECIFY) _____	1	2	3	4	5

1915*	Do you have the national TB control program general manual available in this service area?	YES . . . . . 1 NO 2	→ 1916A
1916*	May I see national TB control program general manual?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
1916A	Do you have the PAL guideline available in this service area?	YES . . . . . 1 NO 2	→ 1917
1916B	May I see the PAL guidelines?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
1917	Do you have any guidelines for the management of HIV and TB co-infection available in this service area? THIS MAY BE PART OF OTHER GUIDELINE	YES . . . . . 1 NO 2	→ 1919
1918	May I see the guidelines for the management of HIV and TB co-infection?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
1919	Do you have any guidelines related to MDR-TB treatment available in this service area? THIS MAY BE PART OF OTHER GUIDELINE	YES . . . . . 1 NO 2	→ 1921
1920	May I see the guidelines on treatment of MDR-TB?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
1921*	**CHECK Q1903** RESPONSES 1, 3, 4 OR 7 CIRCLED ☐ RESPONSES 1, 3, 4 OR 7 NOT CIRCLED ☐		→ 1950
1922*	Do you maintain any sputum containers at this service site for collecting sputum specimen?	YES . . . . . 1 NO 2	→ 1950
1923	May I see a sputum container?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. . . . . 2 NOT AVAILABLE TODAY. 4	

INFECTION CONTROL

1950	ASSESS THE TB ROOM OR AREA FOR THE ITEMS . LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051] . . . . . 12 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY SERVICES [Q1651]. . . . . 17 STI [Q1851]. . . . . 18 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. . . . . 31 → 1953

1951	**INFECTION CONTROL AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND COLOR CODED PLASTIC BIN LINER / LABELED BIN (RED, GREEN, YELLOW AND BLUE)	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT/ANTISEPTICS [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES, OR AUTO-DISABLE SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13*	INJECTION SAFETY PRECAUTION GUIDELINES FOR STANDARD PRECAUTIONS (Surakchhit sui ko niti)	1	2	3
14*	NEEDLE DESTROYER	1	2	3
15*	METHYLATED SPIRIT AND GLYCIRINE 70:30	1	2	3

1952	DESCRIBE THE SETTING OF THE ROOM OR AREA	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4

1953	**CHECK Q214** TB MEDS STORED IN OTHER LOCATION OR NOT STOCKED **(RESPONSE 1 NOT CIRCLED)**	TB MEDICINES STORED IN TB SERVICE AREA **(RESPONSE 1 CIRCLED)** → 931

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 20: HIV TESTING AND COUNSELLING (HTC)

2000	**CHECK Q102.11** HIV TESTING AND / OR COUNSELLING AVAILABLE IN FACILITY ☐	NO HIV TESTING OR COUNSELING SERVICES IN FACILITY NEXT SECTION OR SERVICE SITE ☐ ←	

ASK TO BE SHOWN THE MAIN LOCATION IN THE FACILITY WHERE HIV TESTING & / OR COUNSELLING SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT HIV TESTING & / OR COUNSELLING SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

2001	How many days in a month are HIV testing services offered at this facility? USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	NUMBER OF DAYS. . . . . ☐☐ ONLY COUNSELING, NO TESTING. 00	
2002	When a provider wants a client to receive an HIV test, or when a client agrees to an HIV test, what is the procedure that is followed? In other words, what are the possible options for the client to receive the test? AFTER RESPONSE IS PROVIDED, PROBE FOR ANY OTHER PROCEDURES USED FOR PROVIDING THE HIV TEST. CIRCLE ALL THAT APPLY	HIV RAPID TEST THIS SERVICE SITE. . . . . A BLOOD DRAWN HERE, SENT TO LAB IN FACILITY. . . . . B CLIENT SENT TO OTHER SITE IN FACILITY. . . . . C CLIENT SENT TO LAB IN FACILITY. . . . . D CLIENT SENT TO EXTERNAL SITE. . . . . E BLOOD DRAWN HERE SENT TO EXTERNAL SITE . . . . . F	
2003	**CHECK Q2002** HIV RAPID TESTING THIS SERVICE SITE ("A" CIRCLED) ☐ ↓	NO HIV RAPID TESTING AT THIS SERVICE SITE ("A" NOT CIRCLED) ☐ →	2005

		(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
2004*	Please tell me if any of the following HIV rapid diagnostic test (RDT) kits are available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NO, NEVER AVAILABLE
01	DETERMINE	1	2	3	4	5
02	UNIGOLD	1	2	3	4	5
03	STATPACK	1	2	3	4	5
04	TRIDOT	1	2	3	4	5
05	OTHER (SPECIFY) _____	1	2	3	4	5

2005	Is an individual client chart/record/card/ maintained for clients who receive services through this service site? (e.g., health booklet) This refers to any system, where individual information about a client is recorded so that a record of all care and services is available in one document?	YES. . . . . 1 NO INDIVIDUAL CLIENT CHART/RECORD. 2	→ 2007
2006	May I see a copy of the individual client chart or record	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
2007*	Do you have the ***national HIV testing and counseling guidelines*** available in this service area?	YES. . . . . 1 NO 2	→ 2010A
2008*	May I see the national HIV testing and counseling guidelines?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
2010A	**CHECK Q2002** HIV TESTING AVAILABLE IN FACILITY (ANY OF CODES "A", "B", "C", "D" OR "F" CIRCLED) ☐ ↓	NO HIV TESTING SERVICES IN FACILITY (ONLY CODE "E" CIRCLED) ☐ →	2014
2011	Do staff working in this facility have access to HIV post-exposure prophylaxis, i.e., PEP?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
2012*	Are there any written PEP chart or flex for post-exposure prophylaxis available in this site? MAY BE PART OF ANOTHER DOCUMENT	YES. . . . . 1 NO. 2	→ 2014
2013*	May I see this PEP chart or flex?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
2014	**CHECK Q2002** BLOOD DRAWN THIS SERVICE SITE ("A" OR "B" OR "F" CIRCLED) ☐ ↓	NO BLOOD DRAWN THIS SERVICE SITE (NEITHER "A" NOR "B" NOR "F" CIRCLED) ☐ →	2052

INFECTION CONTROL

2050	ASSESS THE HIV COUNSELING AND TESTING ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051] . . . . . 12 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY SERVICES [Q1651]. . . . . 17 STI [Q1851]. . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 → 2053 NOT PREVIOUSLY SEEN. 31

2051	**INFECTION CONTROL AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND COLOR CODED PLASTIC BIN LINER / LABELED BIN (RED, GREEN, YELLOW AND BLUE)	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT/ANTISEPTICS [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR AUTO-DISABLE SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13*	INJECTION SAFETY PRECAUTION GUIDELINES FOR STANDARD PRECAUTIONS (Surakchhit sui ko niti)	1	2	3
14*	NEEDLE DESTROYER	1	2	3
15*	METHYLATED SPIRIT AND GLYCIRINE 70:30	1	2	3

2052	DESCRIBE THE SETTING OF THE ROOM OR AREA	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4
2053*	Do you have condoms available in this service site to give to clients receiving HIV counseling and testing services?	YES. . . . . 1 NO . . . . . 2 **NEXT SECTION OR SERVICE SITE**
2054	May I see some of the condoms?	OBSERVED, AT LEAST ONE VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NOT AVAILABLE TODAY. 4

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 21: HIV TREATMENT

2100	**CHECK Q102.12** HIV TREATMENT SERVICES OFFERED IN FACILITY ☐ NO HIV TREATMENT SERVICES IN FACILITY ☐ → NEXT SECTION OR SERVICE SITE		
	ASK TO BE SHOWN THE MAIN LOCATION IN THE FACILITY WHERE HIV TREATMENT SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT HIV TREATMENT SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
2101*	Do this facility provide antiretroviral therapy (ART)?	YES. . . . . 1 NO. 2	
2102	Do providers in this facility provide treatment follow-up services for persons on ART, including providing community-based services?	YES. . . . . 1 NO. 2	
2103	**CHECK Q2101 AND Q2102** RESPONSE "1" CIRCLED IN EITHER Q2101 OR Q2102 OR IN BOTH ☐ RESPONSE "1" CIRCLED IN NEITHER Q2101 NOR Q2102 ☐ → NEXT SECTION OR SERVICE SITE		
2104*	Do you have the *National guideline for ART?*	YES. . . . . 1 NO. 2	→ 2105A
2105	May I see the National guideline for ART the management of HIV/AIDS?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
2105A*	Do you have the national guideline for the management of HIV and AIDS in children?	YES. . . . . 1 NO. 2	→ 2108
2105B*	May I see this guidelines?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

PRE-ART BASELINE TESTS

2108* For each of the following tests, please tell me if it is conducted as ***baseline*** routinely, selectively, or never, ***before starting*** a client on ART.

		BASELINE TEST CONDUCTED			
	TEST	ROUTINELY	SELECTIVELY	NO/NEVER	DK
01	Hemoglobin/hematocrit	1	2	3	8
02	Full blood count (Hemogram)	1	2	3	8
03	CD4 T Cell count	1	2	3	8
04	HIV RNA Viral load	1	2	3	8
05	Pregnancy test for women	1	2	3	8
06*	Renal function tests (serum creatinine and urea)	1	2	3	8
07	Urinalysis	1	2	3	8
08	Liver function tests	1	2	3	8
09	TB sputum test	1	2	3	8
10	Hepatitis B	1	2	3	8
11	Chest X-ray	1	2	3	8
12	Any other routine tests _____ (SPECIFY)	1	2	3	8
13*	Blood sugar level	1	2	3	8
14*	Cervical pap smear	1	2	3	8
15*	Hepatitis C	1	2	3	8

TESTS TO MONITOR CLIENTS ON ART

2109* For each of the following tests, please tell me if a ***follow-up test*** is conducted routinely, selectively, or never ***while the client is on*** ART **(i.e., for monitoring**).

	TEST	FOLLOW-UP TEST CONDUCTED			
		ROUTINELY	SELECTIVELY	NO/NEVER	DK
01	Hemoglobin/hematocrit	1	2	3	8
02	Full blood count	1	2	3	8
03	CD4 T Cell count	1	2	3	8
04	HIV RNA Viral load	1	2	3	8
05	Pregnancy test for women	1	2	3	8
06*	Renal function tests (serum creatinine and urea)	1	2	3	8
07	Urinalysis	1	2	3	8
08	Liver function tests	1	2	3	8
09	TB sputum test	1	2	3	8
10	Hepatitis B	1	2	3	8
11	Chest X-ray	1	2	3	8
12	Any other routine tests _____ (SPECIFY)	1	2	3	8
13*	Blood sugar level	1	2	3	8
14*	Cervical pap smear	1	2	3	8
15*	Hepatitis C	1	2	3	8

2110 **CHECK Q216**

ARV MEDICINES STORED IN OTHER LOCATION OR NOT STOCKED **(RESPONSE 1 OR 5 NOT CIRCLED)** ☐

ARV MEDICINES STORED IN ART SERVICE AREA **(RESPONSE 1 OR 5 CIRCLED)** ☐ → 941

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 22: HIV CARE AND SUPPORT

2200	**CHECK Q102.13** HIV CARE AND SUPPORT SERVICES AVAILABLE IN FACILITY ☐ ↓ NO HIV CARE AND SUPPORT SERVICES IN FACILITY ☐ → NEXT SECTION OR SERVICE SITE	

ASK TO BE SHOWN THE MAIN LOCATION IN THE FACILITY WHERE HIV CARE AND SUPPORT SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT HIV CARE AND SUPPORT SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS

	Please tell me if providers in this facility provide the following services for HIV/AIDS clients:	YES	NO	DON'T KNOW
01*	Prescribe treatment for any opportunistic infections or symptoms related to HIV/AIDS?	1	2	8
04	Provide or prescribe palliative care for patients, such as symptom or pain management, or nursing care for the terminally ill, or severely debilitated clients	1	2	8
05*	Provide nutritional support services? i.e., client education and provision of nutritional supplements	1	2	8
06	Prescribe or provide fortified protein supplementation (FPS)	1	2	8
07	Care for pediatric HIV/AIDS patients	1	2	8
08*	Prescribe or provide preventive treatment for TB	1	2	8
09*	Cotrimoxazole preventive therapy for opportunistic infections	1	2	8
10	Provide or prescribe micronutrient supplementation, such as vitamins or iron	1	2	8
11	Family planning counseling and/or services	1	2	8
12*	Provide condoms	1	2	8

2202*	Is there a system for routinely screening and testing HIV-positive clients for TB?	YES. . . . . 1 NO SYSTEM. 2	→ 2204
2203*	May I see the record or evidence of such a system? Observe record	SYSTEM OR REGISTER OBSERVED. . . . . 1 SYSTEM OR REGISTER REPORTED, NOT SEEN. 2	
2204*	Do you have the national guidelines for the clinical management of HIV/AIDS available in this service area?	YES. . . . . 1 NO. 2	→ 2205A
2205*	May I see the national guidelines for the clinical management of HIV/AIDS?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
2205A*	Do this facility provide Community Care Center (CCC) service?	YES. . . . . 1 NO. 2	→ 2208
2206	Do you have guidelines on Community and Home Based Care (CHBC)?	YES. . . . . 1 NO. 2	→ 2208
2207*	May I see the CHBC guidelines?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
2208	Do you have condoms available in this service site to give to clients receiving services?	YES. . . . . 1 NO. . . . . 2 **NEXT SECTION** ← ☐	
2209	May I see some condoms?	OBSERVED, AT LEAST ONE VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NOT AVAILABLE TODAY. 4	

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 23: NON-COMMUNICABLE DISEASES

2300	**CHECK Q102.14** CHRONIC DISEASE SERVICES AVAILABLE FROM FACILITY →	CHRONIC DISEASE SERVICES NOT AVAILABLE FROM FACILITY → NEXT SECTION OR SERVICE SITE	

ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE CLIENTS WITH NON-COMMUNICABLE OR CHRONIC CONDITIONS SUCH AS DIABETES AND CARDIOVASCULAR DISEASES ARE SEEN. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF SUCH SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

DIABETES

2301	Do providers in this facility diagnose and/or manage **diabetes.**	YES, DIAGNOSE ONLY. . . . . 1 YES, TREAT ONLY. . . . . 2 YES, DIAGNOSE AND TREAT. . . . . 3 NO 4	→ 2310
2304*	Do you have ***any guidelines*** for the diagnosis and management of diabetes available in this service area?	YES. . . . . 1 NO. 2	→ 2310
2305*	May I see the guidelines?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

CARDIO-VASCULAR DISEASES

2310	Do providers in this facility diagnose and/or manage **cardiovascular diseases** such as hypertension in patients?	YES, DIAGNOSE ONLY. . . . . 1 YES, TREAT ONLY. . . . . 2 YES, DIAGNOSE AND TREAT. . . . . 3 NO 4	→ 2320
2313*	Do you have ***any guidelines*** for the diagnosis and management of cardio-vascular diseases available in this service area?	YES. . . . . 1 NO. 2	→ 2320
2314*	May I see the guidelines?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

RESPIRATORY

2320	Do providers in this facility diagnose and/or manage **chronic respiratory diseases** such as **COPD** in patients?	YES, DIAGNOSE ONLY. . . . . 1 YES, TREAT ONLY. . . . . 2 YES, DIAGNOSE AND TREAT. . . . . 3 NO 4	→ 2330
2323*	Do you have ***any*** guidelines for the diagnosis and/ management of chronic respiratory diseases available in this service area?	YES. . . . . 1 NO 2	→ 2330
2324*	May I see the guidelines?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

BASIC SUPPLIES AND EQUIPMENT

2330	ASSESS THE ROOM OR AREA FOR THE BASIC SUPPLIES AND EQUIPMENT LISTED BELOW. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION SECTION (Q700). . . . . 1 NOT PREVIOUSLY SEEN. 2	→ 2350

		(A) AVAILABLE			(B) FUNCTIONING		
2331	I would like to know if the following items are available today in the main service area and are functioning ASK TO SEE ITEMS.	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	ADULT WEIGHING SCALE	1 → b	2 → b	3 → 02	1	2	8
02	CHILD WEIGHING SCALE [250 GRAM GRADATION]	1 → b	2 → b	3 → 03	1	2	8
03	INFANT WEIGHING SCALE [100 GRAM GRADATION]	1 → b	2 → b	3 → 04	1	2	8
04	STADIOMETER [OR HEIGHT ROD] FOR MEASURING HEIGHT	1 → b	2 → b	3 → 05	1	2	8
05	MEASURING TAPE [FOR CIRCUMFERENCE]	1 → b	2 → b	3 → 06	1	2	8
06	THERMOMETER	1 → b	2 → b	3 → 07	1	2	8
07	STETHOSCOPE	1 → b	2 → b	3 → 08	1	2	8
08	DIGITAL BP APPARATUS	1 → b	2 → b	3 → 09	1	2	8
09	MANUAL BP APPARATUS	1 → b	2 → b	3 → 10	1	2	8
10	LIGHT SOURCE (FLASHLIGHT ACCPTABLE)	1 → b	2 → b	3 → 11	1	2	8
11	SELF-INFLATING BAG AND MASK [ADULT]	1 → b	2 → b	3 → 12	1	2	8
12	SELF-INFLATING BAG AND MASK [PEDIATRIC]	1 → b	2 → b	3 → 13	1	2	8
13*	NEBULIZER	1 → b	2 → b	3 → 14	1	2	8
14	SPACERS FOR INHALERS	1	2	3			
15	OXYGEN FLOW METERS	1 → b	2 → b	3 → 16	1	2	8
16	PULSE OXIMETER	1 → b	2 → b	3 → 17	1	2	8
17	OXYGEN CONCENTRATORS	1 → b	2 → b	3 → 18	1	2	8
18	FILLED OXYGEN CYLINDER	1 → b	2 → b	3 → 19	1	2	8
19	OXYGEN DISTRIBUTION SYSTEM	1 → b	2 → b	3 → 20	1	2	8
20	INTRAVENOUS INFUSION KITS - ADULT	1	2	3			
21	INTRAVENOUS INFUSION KITS - PEDIATRIC	1	2	3			

CLIENT EXAMINATION ROOM

2350	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051] . . . . . 12 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY SERVICES [Q1651]. . . . . 17 STI [Q1851]. . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. . . . . 31 → NEXT SECTION / SERVICE SITE

2351	**INFECTION CONTROL AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND COLOR CODED PLASTIC BIN LINER / LABELED BIN (RED, GREEN, YELLOW AND BLUE)	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT/ANTISEPTICS [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE USE STANDARD DISPOSABLE SYRINGS WITH NEEDLES, OR AUTO-DISABLE SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13*	INJECTION SAFETY PRECAUTION GUIDELINES FOR STANDARD PRECAUTIONS (Surakchhit sui ko niti)	1	2	3
14*	NEEDLE DESTROYER	1	2	3
15*	METHYLATED SPIRIT AND GLYCIRINE 70:30	1	2	3

2352	DESCRIBE THE SETTING OF THE ROOM OR SERVICE AREA	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 24: MINOR SURGICAL SERVICES

2400	**CHECK Q102.15** MINOR SURGERY AVAILABLE ↓ MINOR SURGERY NOT AVAILABLE → NEXT SECTION OR SERVICE SITE	

ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE MINOR SURGERIES ARE DONE.
FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF MINOR SURGERIES IN THE FACILITY.
INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

ASK TO SEE THE ROOM OR AREA WHERE MINOR SURGERIES TAKE PLACE AND ASK TO SEE THE ITEMS BELOW

2401	Please tell me if the following equipment are available at this site today and is functioning. I would like to see them	(A) AVAILABLE			(B) FUNCTIONING		
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	NEEDLE HOLDER	1 b	2 b	3 → 02	1	2	8
02	SCAPEL HANDLE WITH BLADE	1 b	2 b	3 → 03	1	2	8
03	RETRACTOR	1 b	2 b	3 → 04	1	2	8
04	SURGICAL SCISSORS	1 b	2 b	3 → 05	1	2	8
05	NASOGASTRIC TUBE (10-16G)	1 b	2 b	3 → 06	1	2	8
06	TORNIQUET	1 b	2 b	3 → 2402	1	2	8

2402	Please tell me if any of the following materials or medicines is available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE, NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	ABSORBABLE SUTURE MATERIAL	1	2	3	4	5
02	NON-ABSORBABLE SUTURE MATERIAL	1	2	3	4	5
03	SKIN DISINFECTANT	1	2	3	4	5
04	LIDOCAINE / LIGNOCAINE INJECTION	1	2	3	4	5
05	KETAMINE INJECTION	1	2	3	4	5

2403	Do you have guidelines on Integrated management of emergency and essential surgical care (IMEESC)?	YES . . . . . 1 NO . . . . . 2 →	2450
2404	May I see the guidelines on Integrated management of emergency and essential surgical care?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	

INFECTION CONTROL

2450	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051] . . . . . 12 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY SERVICES [Q1651]. . . . . 17 STI [Q1851]. . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 NOT PREVIOUSLY SEEN. . . . . 31 → NEXT SECTION / SERVICE SITE

2451	**INFECTION CONTROL AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND COLOR CODED PLASTIC BIN LINER / LABELED BIN (RED, GREEN, YELLOW AND BLUE)	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT/ANTISEPTICS [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES, OR AUTO-DISABLE SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13*	INJECTION SAFETY PRECAUTION GUIDELINES FOR STANDARD PRECAUTIONS (Surakchhit sui ko niti)	1	2	3
14*	NEEDLE DESTROYER	1	2	3
15*	METHYLATED SPIRIT AND GLYCIRINE 70:30	1	2	3

2452	DESCRIBE THE SETTING OF THE ROOM OR AREA	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 25: CESAREAN DELIVERY

2500	**CHECK Q102.16** CESAREAN SECTION DONE IN FACILITY CESAREAN DELIVERY **NOT** DONE IN FACILITY NEXT SECTION OR SERVICE SITE		

ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE CESAREAN DELIVERIES ARE DONE.
FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF SUCH SERVICES IN THE FACILITY.
INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

2501	Does the facility have a health worker who can perform Cesarean delivery (section) present at the facility or on call 24 hours a day (including weekends and on public holidays)?	YES. . . . . 1 NO. 2	→ 2504
2502	Is there a duty schedule or call list for 24-hr staff assignment?	YES. . . . . 1 24-HOUR DUTY SCHEDULE NOT MAINTAINED. . 2	→ 2504
2503	May I see the duty schedule or call list for 24-HR staff assignment?	SCHEDULE OBSERVED. . . . . 1 SCHEDULE REPORTED, NOT SEEN. 2	
2504*	Does this facility have an anesthetist/anesthetist assistant present in the facility or on call 24 hours a day (including weekends and on public holidays?)	YES. . . . . 1 NO. 2	→ 2507
2505	Is there a duty schedule or call list?	YES. . . . . 1 24-HOUR DUTY SCHEDULE NOT MAINTAINED. . 2	→ 2507
2506	May I see the duty schedule or call list?	SCHEDULE OBSERVED. . . . . 1 SCHEDULE REPORTED, NOT SEEN. 2	
2507	Have Cesarean deliveries been performed in this facility during the past 3 months?	YES. . . . . 1 NO. 2	

ASK TO SEE THE ROOM OR AREA WHERE CESAREAN DELIVERIES ARE DONE AND ASK TO SEE THE ITEMS BELOW

		(A) AVAILABLE			(B) FUNCTIONING		
2510	Please tell me if the following equipment are available at this site today and is functioning. I would like to see them	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	ANESTHESIA MACHINE	1 b	2 b	3 → 02	1	2	8
02	TUBINGS AND CONNECTORS (TO CONNECT ENDOTRACHEAL TUBE)	1 b	2 b	3 → 03	1	2	8
03	OROPHARYNGEAL AIRWAY (ADULT)	1 b	2 b	3 → 04	1	2	8
04	OROPHARYNGEAL AIRWAY (PEDIATRIC)	1 b	2 b	3 → 05	1	2	8
05	MAGILLS FORCEPS - ADULT	1 b	2 b	3 → 06	1	2	8
06	MAGILLS FORCEPS - PEDIATRIC	1 b	2 b	3 → 07	1	2	8
07	ENDOTRACHEAL TUBE CUFFED SIZES 3.0 - 5.0	1 b	2 b	3 → 08	1	2	8
08	ENDOTRACHEAL TUBE CUFFED SIZES 5.5 - 9.0	1 b	2 b	3 → 09	1	2	8
09	INTUBATING STYLET	1 b	2 b	3 → 10	1	2	8
10	SPINAL NEEDLE	1 b	2 b	3 → NEXT SECTION/SERVICE SITE	1	2	8

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 26: BLOOD TYPING AND COMPATIBILITY TESTING

2600	**CHECK Q102.18** BLOOD TYPING SERVICES AVAILABLE FROM FACILITY ☐ BLOOD TYPING SERVICES NOT AVAILABLE FROM FACILITY ☐ NEXT SECTION OR SERVICE SITE ←					
2601	Please tell me if any of the following reagents or equipment is available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	Anti-A Reagent	1	2	3	4	5
02	Anti-B Reagent	1	2	3	4	5
03	Anti-D Reagent	1	2	3	4	5
04	COOMB'S REAGENT	1	2	3	4	5
05	Anti-A,B Reagent	1	2	3	4	5

SECTION 27: BLOOD TRANSFUSION SERVICES

2700	**CHECK Q102.19** BLOOD TRANSFUSION AVAILABLE FROM FACILITY BLOOD TRANSFUSION NOT AVAILABLE FROM FACILITY NEXT SECTION OR SERVICE SITE		

ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE BLOOD IS COLLECTED, STORED, PROCESSED OR HANDLED PRIOR TO TRANSFUSION. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF BLOOD TRANSFUSION SERVICES IN THE FACILITY INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

2701*	What is the source of the blood that is transfused in this facility? PROBE FOR A COMPLETE LIST OF SOURCES OF BLOOD.	NATIONAL BLOOD BANK. . . . . A REGIONAL BLOOD BANK. . . . . B DISTRICT BLOOD BANK. . . . . C HOSPITAL BLOOD BANK. . . . . D OTHER_____ X (SPECIFY)	
2702	Has blood transfusion been done in this facility in an obstetric context (i.e., for maternal care) during the past 3 months?	YES. . . . . 1 NO. 2	

SCREENING FOR INFECTIOUS DISEASES

2710	Is blood that is transfused in this facility screened, ***either in this facility or externally,*** for any infectious diseases prior to transfusion?	YES. . . . . 1 NO. 2	→ 2720
2711	Is the blood that is transfused screened only in the facility, only at an external facility, or both?	ONLY IN THIS FACILITY. . . . . 1 ONLY AT AN EXTERNAL FACILITY. . . . . 2 BOTH INTERNALLY AND EXTERNALLY. 3	

2712*	Is the blood that is transfused in the facility screened, ***either in this facility or externally,*** for any of the following infectious diseases? IF YES, ASK: Is the blood "always", "sometimes", or "rarely" screened?	ALWAYS	SOMETIMES	RARELY	NO
01	HIV	1	2	3	4
02	SYPHILIS	1	2	3	4
03	HEPATITIS B	1	2	3	4
04	HEPATITIS C	1	2	3	4

2713	Do you ever send blood sample outside the facility for screening for any of the tests mentioned above?	YES . . . . . 1 NO 2	→ 2720

		(A) SEND SPECIMEN OUT		(B) RECORD OF OUTSIDE TEST	
2714*	For which of the following tests do you send blood sample outside the facility for screening? ASK TO SEE DOCUMENTATION	YES	NO	YES	NO
01	HIV	1 b	2 → 02	1	2
02	SYPHILIS	1 b	2 → 03	1	2
03	HEPATITIS B	1 b	2 → 04	1	2
04	HEPATITIS C	1 b	2 → 2720	1	2

BLOOD STORAGE

2720	Has the facility run out of blood for more than one day anytime during the past 3 months?	YES. . . . . 1 NO. 2	
2721	Is there a blood bank fridge or other refrigerator available for blood storage in this service area?	YES. . . . . 1 NO. 2	→ 2724
2722	May I see the blood bank fridge or other refrigerator?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	→ 2724
2723*	WHAT IS THE TEMPERATURE IN THE BLOOD BANK FRIDGE OR OTHER REFRIGERATOR?	BETWEEN +2 AND +6 DEGREES. . . . . 1 ABOVE +6 DEGREES. . . . . 2 BELOW +2 DEGREES. . . . . 3 THERMOMETER NOT FUNCTIONAL. . . . . 4 NO THERMOMETER 5	
2724*	Do you have national guidelines on screening donated blood for transfusion for transmissible infections?	YES. . . . . 1 NO. . . . . 2 NEXT SECTION OR SERVICE SITE	
2725*	May I see this guideline?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	

SECTION 30: GENERAL FACILITY LEVEL CLEANLINESS

3000	ASSESS GENERAL CLEANLINESS / CONDITIONS OF FACILITY		YES	NO
01	**FLOOR:** SWEPT, NO OBVIOUS DIRT OR WASTE		1	2
02	**COUNTERS/TABLES/CHAIRS:** WIPED CLEAN- NO OBVIOUS DUST OR WASTE		1	2
03	NEEDLES, SHARPS OUTSIDE SHARPS BOX		1	2
04	SHARPS BOX OVERFLOWING OR TORN/PIERCED		1	2
05	BANDAGES/INFECTIOUS WASTE LYING UNCOVERED		1	2
06	**WALLS:** SIGNIFICANT DAMAGE		1	2
07	**DOORS:** SIGNIFICANT DAMAGE		1	2
08	**CEILING:** WATER STAINS OR DAMAGE		1	2
	INTERVIEW END TIME USE 24 HOURS FORMAT		HOURS	MINUTES
	THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.			

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

NAME OF THE SUPERVISOR: _____ DATE: _____

NEPAL HEALTH FACILITY SURVEY - 2015

HEALTH WORKER INTERVIEW

Facility Number: | | | | | |

Provider SERIAL Number: | | | **[FROM PROVIDER LISTING FORM]**

Provider Sex: (1=MALE; 2=FEMALE) |

Interviewer Code: | | |

Number of ANC Observations Associated with Provider. . . . . . |

Number of FP Observations Associated with Provider. . . . . . |

Number of Sick Child Observations Associated with Provider. . . . . . |

INDICATE IF PROVIDER WAS PREVIOUSLY INTERVIEWED IN ANOTHER FACILITY. IF YES, RECORD NAME AND FACILITY NUMBER WHERE HE/SHE WAS INTERVIEWED

YES, PREVIOUSLY INTERVIEWED **1**

NAME & NUMBER OF FACILITY | | | | | | → **END**

NO, NOT PREVIOUSLY INTERVIEWED **2**

READ THE FOLLOWING CONSENT FORM

Good day! My name is _____. We are here on behalf of New ERA conducting a survey of health facilities to assist the government in knowing more about health services in Nepal.

Now I will read a statement explaining the study.

Your facility was selected to participate in this study. We will be asking you several questions about the types of services that you personally provide, as well as questions about trainings you have received.

The information you provide us may be used by New ERA, other organizations or researchers, for planning service improvements or further studies of services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of the respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will collaborate with the study.

Do you have any questions about the study? Do I have your agreement to proceed?

_____
Interviewer's signature

				2	0	1	
DAY		MONTH		YEAR			

SIGNATURE OF INTERVIEWER INDICATES INFORMED CONSENT WAS PROVIDED.

101	May I begin the interview now?	YES. . . . . 1 NO. 2	→**END**

1. EDUCATION AND EXPERIENCE

102	I would like to ask you some questions about your educational background. How many years of education have you completed in total, starting from your primary, secondary and further education?	YEARS . . . . . ☐☐.☐	
103*	What is your current occupational category or qualification? For example, are you a registered nurse, or generalist medical doctor or a specialist medical doctor?	GENERALIST MEDICAL DOCTOR (MDGP). . . . . 01 GYNECOLOGIST / OBSTETRICIAN . . . . . 02 ANESTHESIOLOGIST . . . . . 03 PATHOLOGIST . . . . . 04 GENERAL SURGEON. . . . . 05 PEDIATRICIAN . . . . . 06 OTHER SPECIALISTS MEDICAL DOCTORS. . . . . 07 MEDICAL OFFICER (MBBS, BDS) . . . . . 08 ANESTHETIC ASSISTANT . . . . . 09 NURSE (MN, BSC NURSE, BN, PCL) / AUXILLARY NURSE MIDWIFE (ANM). . . . . 10 LABORATORY TECHNOLOGIST / OFFICER / LABORATORY TECHNICIAN / LABORATORY ASSISTANT. . . . . 11 HEALTH ASSISTANT (HA) / AHW / SAHW / PUBLIC HEALTH INSPECTOR. . . . . 12 COUNSELOR WITH CLINICAL QUAL. (HTC ONLY). . . . . 16 COUNSELOR WITHOUT CLINICAL QUAL. (HTC ONLY). . . . . 17 OTHER CLINICAL STAFF NOT LISTED ABOVE . . . . . 18 NO TECHNICAL QUALIFICATION / NON CLINICAL STAFF. 95	
104	What year did you graduate (or complete) with this qualification? IF NO TECHNICAL QUALIFICATION (103=95), ASK: What year did you complete any basic training for your current occupational category?	YEAR ☐☐☐☐	
105	In what year did you start working in this facility?	YEAR ☐☐☐☐	
106	Have you received any dose of Hepatitis B vaccine? IF YES, ASK: How many doses have you received so far?	YES, 1 DOSE. . . . . 1 YES, 2 DOSES. . . . . 2 YES, 3 OR MORE DOSES. . . . . 3 NO. 4	→ 108
107*	Did you receive any of the Hepaptitis B vaccinations as part of your services in this facility?	YES. . . . . 1 NO. 2	
108	Are you a manager or in-charge for any clinical services?	YES. . . . . 1 NO. 2	

2. GENERAL TRAINING / COMMUNICABLE / NON-COMMUNICABLE DISEASES

200*	I will like to ask you a few questions about in-service training you have received related to your work. In-service training refers to training you have received related to your work since you started working. I will start with some general topics. Note that the training topics I will mention may have been covered as stand alone trainings, or they may have been covered under another training topic. Have you received any in-service training, training updates or refresher training in any of the following topics [READ TOPIC] IF YES, ASK: Was the ***training, training update or refresher training*** within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01*	Standard precautions, including hand hygiene, cleaning and disinfection, waste management, needle stick and sharp injury prevention? May be part of any training, like Infection prevention / IP training.	1	2	3
02	Any specific training related to injection safety practices or safe injection practices	1	2	3
03*	Revised Health Management Information Systems (HMIS) or reporting requirements for any service	1	2	3
06	Integrated Management for Emergency and Essential Surgical Care (IMEESC)	1	2	3
07	Other general training (SPECIFY)_____	1	2	3

201*	**CHECK [Q103] FOR PROVIDER OCCUPATIONAL CATEGORY / QUALIFICATION** CODE [11] (i.e., LABORATORY-RELATED) CIRCLED ☐ → 700 CODE [11] **NOT** CIRCLED ☐		
	I will now ask you a few questions about services you **personally** provide ***in your current position in this facility*** and any in-service training, training updates or refresher trainings you may have received related to that service. Please remember we are talking about services you provide in your current position in this facility. The training topics I will mention may have been covered as a stand-alone training, or covered as part of another training topic.		
202	In your **current** position, and as a part of your work for this facility, do you personally provide any services that are designed to be ***youth or adolescent friendly?*** i.e., designed with the specific aim to encourage youth or adolescent utilization?	YES. . . . . 1 NO. 2	
203*	Have you received any ***in-service training, training updates or refresher training*** on topics specific to youth or adolescent friendly services? (e.g. Adolescent Friendly Services (AFS) or Youth Friendly Services (YFS) training) IF YES: Was the training, training update or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS. . . . . 1 YES, OVER 24 MONTHS AGO. . . . . 2 NO TRAINING OR UPDATES. 3	
203A	**CHECK Q103 FOR PROVIDER OCCUPATIONAL CATEGORY / QUALIFICATION** CODE 16 OR 17 (COUNSELOR) CIRCLED ☐ → 604 CODE 16 NOR 17 (COUNSELOR) **NOT** CIRCLED ☐		

MALARIA

204	In your **current** position, and as a part of your work for this facility, do you personally diagnose and/or treat malaria?	YES. . . . . 1 NO. 2	
205	Have you received any in-service training, training updates or refresher trainings on topics related to diagnosis and/or treatment of malaria?	YES. . . . . 1 NO. 2	→ 207

206*	Have you received any ***in-service training, training updates or refresher trainings*** in any of the following topics [READ TOPIC]: IF YES: Was the training, training update or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	DIAGNOSING MALARIA IN ADULTS	1	2	3
02	DIAGNOSING MALARIA IN CHILDREN	1	2	3
03	HOW TO PERFORM MALARIA RAPID DIAGNOSTIC TEST	1	2	3
04	CASE MANAGEMENT / TREATMENT OF MALARIA IN ADULTS	1	2	3
05	CASE MANAGEMENT / TREATMENT OF MALARIA DURING PREGNANCY	1	2	3
07	CASE MANAGEMENT / TREATMENT OF MALARIA IN CHILDREN	1	2	3
08	OTHER TRAINING ON MALARIA (SPECIFY)_____	1	2	3

DIABETES

207	In your **current** position, and as a part of your work for this facility, do you personally diagnose and/or manage **diabetes**?	YES. . . . . 1 NO. 2	
208	Have you received any ***in-service training, training updates or refresher training*** on topics specific to the diagnosis and/or management of diabetes? IF YES: Was the training, training update or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS. . . . . 1 YES, OVER 24 MONTHS AGO. . . . . 2 NO TRAINING OR UPDATES. 3	

CARDIO-VASCULAR DISEASES

209	In your **current** position, and as a part of your work for this facility, do you personally diagnose and/or manage cardio-vascular diseases such as hypertension?	YES. . . . . 1 NO. 2	
210	Have you received any ***in-service training, training updates or refresher training*** on the diagnosis and/or management of cardio-vascular diseases? IF YES: Was the training, training update or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS. . . . . 1 YES, OVER 24 MONTHS AGO. . . . . 2 NO TRAINING OR UPDATES. 3	

CHRONIC RESPIRATORY DISEASES

211	In your **current** position, and as a part of your work for this facility, do you personally diagnose and/or manage chronic respiratory conditions such as chronic obstructive pulmonary disease (COPD)?	YES. . . . . 1 NO. 2	
212	Have you received any ***in-service training, training updates or refresher training*** on the diagnosis and/or management of chronic respiratory diseases? IF YES: Was the training, training update or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS. . . . . 1 YES, OVER 24 MONTHS AGO. . . . . 2 NO TRAINING OR UPDATES. 3	

3. CHILD HEALTH SERVICES

300A	Are you aware of the "**Golden Thousand Days"** period?	YES. . . . . 1 NO. 2	
300	In your **current** position, and as a part of your work for this facility, do you personally provide any **child vaccination** services?	YES. . . . . 1 NO. 2	
301	In your **current** position, and as a part of your work for this facility, do you personally provide any **child growth monitoring** services?	YES. . . . . 1 NO. 2	
302	In your **current** position, and as a part of your work for this facility, do you personally provide any **child curative care** services?	YES. . . . . 1 NO. 2	
303	Have you received any ***in-service training, training updates or refresher training*** on topics related to child health or childhood illnesses?	YES . . . . . 1 NO 2	→ 400

304*	Have you received any ***in-service training or training updates*** in any of the following topics [READ TOPIC] IF YES: Was the training, training update or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	EPI / NIP OR COLD CHAIN MONITORING	1	2	3
02*	INTEGRATED MANAGEMENT OF NEONATAL AND CHILDHOOD ILLNESSES (IMNCI)	1	2	3
03	DIAGNOSIS OF MALARIA IN CHILDREN	1	2	3
04	HOW TO PERFORM MALARIA RAPID DIAGNOSTIC TEST	1	2	3
05	CASE MANAGEMENT / TREATMENT OF MALARIA IN CHILDREN	1	2	3
06	DIAGNOSIS AND/OR TREATMENT OF ACUTE RESPIRATORY INFECTIONS	1	2	3
07	DIAGNOSIS AND/OR TREATMENT OF DIARRHEA	1	2	3
08	MICRONUTRIENT DEFICIENCIES AND/OR NUTRITIONAL ASSESSMENT AND MANAGEMENT	1	2	3
09*	BREASTFEEDING	1	2	3
10*	COMPLIMENTARY FEEDING IN INFANTS	1	2	3
11	PEDIATRIC HIV/AIDS	1	2	3
12	PEDIATRIC ART	1	2	3
13	OTHER TRAINING ON CHILD HEALTH (SPECIFY)_____	1	2	3
'14*	INFANT AND YOUNG CHILD FEEDING TRAINING (IYCF TRAINING)	1	2	3
'15	IRON DEFICIENENCY DISORDER RELATED TRAINING (IMN TRAINING)	1	2	3
16	MATERNAL AND INFANT AND YOUNG CHILD NUTRITION TRAINING (ESSENTIAL NUTRITION ACTIONS TRAINING)	1	2	3

4. FAMILY PLANNING SERVICES

400	In your **current** position, and as a part of your work for this facility, do you personally provide any **family planning** services?	YES. . . . . 1 NO. 2			
401	Have you received any ***in-service training, training updates or refresher training*** on topics related to family planning?	YES. . . . . 1 NO. 2			→ 500
403	Have you received any in-service training, training updates or refresher training in any of the following topics [READ TOPIC] IF YES: Was the training, training update or refresher training within the past 24 months or more than 24 months ago?		YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	GENERAL COUNSELING FOR FAMILY PLANNING		1	2	3
02	IUCD INSERTION AND REMOVAL		1	2	3
03	IMPLANT INSERTION AND REMOVAL		1	2	3
04	PERFORMING NON-SCALPEL VASECTOMY (NSV)		1	2	3
05	PERFORMING MINILAP TUBAL LIGATION		1	2	3
07	FAMILY PLANNING FOR HIV POSITIVE WOMEN		1	2	3
08	POST-PARTUM FAMILY PLANNING, INCLUDING PPIUCD				3
09	OTHER TRAINING ON FAMILY PLANNING (SPECIFY)_____		1	2	3

5. MATRERNAL HEALTH SERVICES

ANC - PNC - PMTCT

500	In your **current** position, and as a part of your work for this facility, do you personally provide any **antenatal care or postnatal care** services? IF YES, PROBE AND INDICATE WHICH SERVICES ARE PROVIDED	YES, ANTENATAL. . . . . 1 YES, POSTNATAL. . . . . 2 YES, BOTH. . . . . 3 NO, NEITHER. 4			
501	Have you received any ***in-service training, training updates or refresher training*** on topics related to antenatal care or postnatal care?	YES. . . . . 1 NO. 2			→ 503
502*	Have you received any ***in-service training, training updates or refresher training*** in any of the following topics [READ TOPIC] IF YES: Was the training, training update or refresher training within the past 24 months or more than 24 months ago?		YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	ANC screening (e.g., blood pressure, urine glucose and protein)		1	2	3
02	Counseling for ANC (e.g., nutrition, FP and newborn care)		1	2	3
03	Complications of pregnancy and their management		1	2	3
04*	Nutritional assessment of the pregnant woman, such as Body Mass Index calculation		1	2	3
05	Other training on ANC or postnatal care (SPECIFY)_____		1	2	3
503	In your current position, and as a part of your work for this facility, do you ***personally*** provide any services that are specifically geared toward preventing mother-to-child transmission of HIV? IF YES, ASK: Which specific services do you provide? INDICATE WHICH OF THE LISTED SERVICES ARE PROVIDED AND PROBE: Anything else?	PREVENTIVE COUNSELING. . . . . A HIV TEST COUNSELING. . . . . B CONDUCT HIV TEST. . . . . C PROVIDE ARV TO MOTHER. . . . . D PROVIDE ARV TO INFANT. . . . . E NO PMTCT SERVICES. . . . . Y			
504	Have you received any ***in-service training, training updates or refresher training*** on topics related to maternal and/or newborn health and HIV/AIDS?	YES. . . . . 1 NO. 2			→ 506
505	Have you received any ***in-service training, training updates or refresher training*** in any of the following topics [READ TOPIC] IF YES: Was the training, training update or refresher training within the past 24 months or more than 24 months ago?		YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	Prevention of mother-to-child transmission (PMTCT) of HIV		1	2	3
02	Newborn nutrition counseling for mother with HIV		1	2	3
03*	Infant and young child feeding for mother with HIV		1	2	3
04	Modified obstetric practices as relates to HIV (e.g., not rupturing membranes)		1	2	3
05	Antiretroviral prophylactic treatment for prevention of mother to child transmission of HIV		1	2	3
06	Other trainings on maternal and/or newborn health and HIV/AIDS (SPECIFY)_____		1	2	3

DELIVERY SERVICES

506	In your **current** position, and as a part of your work for this facility, do you personally provide **delivery services**? By that I mean conducting the actual delivery of newborns?	YES. . . . . 1 NO. 2	→ 509
507	During the past 6 months, approximately how many deliveries have you conducted as the ***main provider (include deliveries conducted for private practice and for facility)?***	TOTAL DELIVERIES [ ][ ][ ][ ]	
508	When was the last time you used a partograph?	NEVER. . . . . 0 WITHIN PAST WEEK. . . . . 1 WITHIN PAST MONTH. . . . . 2 WITHIN PAST 6 MONTHS. . . . . 3 OVER 6 MONTHS AGO. 4	
509	Have you received any ***in-service training, training updates or refresher training*** on topics related to delivery care?	YES. . . . . 1 NO. 2	→ 511

510	Have you received any ***in-service training, training updates or refresher training*** in any of the following topics [READ TOPIC] IF YES: Was the training, training update or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	SBA Integrated Management of Pregnancy and Childbirth (IMPAC)	1	2	3
02	ASBA Comprehensive Emergency Obstetric Care (CEmOC)	1	2	3
03*	Routine care during labor and normal vaginal delivery	1	2	3
04	Active Management of Third Stage of Labor (AMTSL)	1	2	3
05	MNH Update Emergency obstetric care (EmOC)/Life saving skills (LSS) - in general	1	2	3
06	Post abortion care (PAC)	1	2	3
07	Special delivery care practices for preventing mother-to-child transmission of HIV	1	2	3
08*	Comprehensive abortion care (CAC) by MVA			
09*	Medical abortion (MA)			
10	Other training on delivery care (SPECIFY)_____	1	2	3

NEWBORN CARE SERVICES

511	In your **current** position, and as a part of your work for this facility, do you personally provide care for the newborn?	YES. . . . . 1 NO. 2	
512	Have you received any ***in-service training, training updates or refresher training*** on topics related to newborn care?	YES. . . . . 1 NO. 2	→ 600

513*	Have you received any ***in-service training, training updates or refresher training*** in any of the following topics [READ TOPIC] IF YES: Was the training, training update or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	Neonatal resuscitation using bag and mask	1	2	3
02*	*Early* and e*xclusive* breastfeeding	1	2	3
03	Newborn infection management (including injectable antibiotics)	1	2	3
04	Thermal care (including immediate drying and skin-to-skin care)	1	2	3
05*	Sterile cord cutting and appropriate cord care	1	2	3
06*	Kangaroo Mother Care (KMC) for low birth weight babies	1	2	3
07	Other training on newborn care (SPECIFY)_____	1	2	3

6. SEXUALLY TRANSMITTED INFECTIONS - TB - HIV/AIDS

SEXUALLY TRANSMITTED INFECTIONS

600	In your current position, and as part of your work for this facility, do you personally provide any STI services?	YES. . . . . 1 NO. 2	
601	Have you received any ***in-service training, training updates or refresher training*** on topics related to STI services?	YES. . . . . 1 NO. 2	→603

602	Have you received any ***in-service training, training updates or refresher training*** in any of the following topics [READ TOPIC] IF YES: Was the training, training update or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	Diagnosing and treating sexually transmitted infections (STIs)	1	2	3
02	The syndromic management for STIs	1	2	3
03	Drug resistance to STI treatment medications	1	2	3
04	Other training on STI (SPECIFY)_____	1	2	3

PULMONARY TUBERCULOSIS

603*	Now I will ask if you provide certain TB-related services. For each service, regardless of whether you currently provide it, I will also ask if you have received related ***in-service training, training updates or refresher training*** READ THE QUESTIONS FROM COLUMNS A AND B	Do you provide [READ SERVICE]? (a)		Have you received training or training update on [SERVICE]? IF YES, within the past 24 months or more than 24 months ago? (b)		
		YES	NO	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO TRAINING
01	Diagnosis of tuberculosis based on sputum tests using AFB Smear Microscopy	1	2	1	2	3
02	Diagnosis of tuberculosis based on clinical symptoms or TB Diagnostic Algorithm	1	2	1	2	3
03	Treatment prescription for tuberculosis	1	2	1	2	3
04	Treatment follow-up services for tuberculosis	1	2	1	2	3
05	Direct Observation Treatment Short-course (DOTS) strategy	1	2	1	2	3
06	Management of TB - HIV co-infection	1	2	1	2	3
07	Management of DR-TB	1	2	1	2	3
08	PAL training			1	2	3
09	Laboratory modular training			1	2	3
10	TB modular training			1	2	3
11	TB infection control training			1	2	3
12	Other training on TB (SPECIFY)_____			1	2	3

HIV/AIDS SERVICES

604*	Now I will ask if you provide certain HIV-related services. For each service, regardless of whether you currently provide it, I will also ask if you have received related in-service training, training updates or refresher training. READ THE QUESTIONS FROM COLUMNS A AND B	Do you provide [READ SERVICE]? (a)		Have you received training or training update on [SERVICE]? IF YES, within the past 24 months or more than 24 months ago? (b)		
		YES	NO	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO TRAINING
01	Provide counseling related to HIV testing	1	2	1	2	3
02	Conduct the HIV test	1	2	1	2	3
03	Provide any services related to PMTCT	1	2	1	2	3
04	Provide any palliative care services	1	2	1	2	3
05	Provide any ART services, including prescription, counseling, or follow-up	1	2	1	2	3
06	Provide any preventive treatment for opportunistic infections (OIs) such as TB and pneumonia	1	2	1	2	3
07	Provide pediatric AIDS care	1	2	1	2	3
08	Provide HIV/AIDS home-based care	1	2	1	2	3
09	Provide post-exposure prophylaxis (PEP) services	1	2	1	2	3
10*	Stigma and discrimination of people living with HIV/AID (S&D training)	1	2	1	2	3
11	Other training on HIV (SPECIFY)_____			1	2	3

7. DIAGNOSTIC SERVICES

700	In your **current** position, and as a part of your work for this facility, do you personally conduct laboratory tests? CIRCLE 'NO' IF THE PROVIDER ONLY COLLECTS SPECIMENS.	YES. . . . . 1 NO. 2	→ 800

701*	Please tell me if you personally conduct any of the following tests as part of your work in this facility	YES	NO
01	Microscopic examining of sputum for diagnosing tuberculosis	1	2
02	HIV rapid testing	1	2
03*	Any other HIV test, such as PCR, ELISA / CLIA, or Western Blot	1	2
04	Hematology testing, such as anemia testing	1	2
05	CD4 testing	1	2
06	Malaria microscopy	1	2
07	Malaria rapid diagnostic test (mRDT)	1	2

702	Have you received any ***in-service training, training updates or refresher training*** on topics related to the different diagnostic tests you conduct?	YES. . . . . 1 NO. 2	→ 800

703	Have you received any ***in-service training, training updates or refresher training*** in any of the following topics [READ TOPIC] IF YES: Was the training, training update or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	Microscopic examination of sputum for diagnosing tuberculosis	1	2	3
02	HIV testing	1	2	3
03	CD4 testing	1	2	3
04	Blood screening for HIV prior to transfusion	1	2	3
05	Blood screening for Hepatitis B prior to transfusion	1	2	3
06	Tests for monitoring ART such as TLC and serum creatinine.	1	2	3
07	Malaria microscopy	1	2	3
08	Malaria rapid diagnostic test (mRDT)	1	2	3
09	Other training on diagnostic tests (SPECIFY)_____	1	2	3

8. WORKING CONDITIONS IN FACILITY

800	Now I want to ask you a few more questions about your work in this facility. In an average week, how many hours do you work in this facility? IF WEEKS ARE NOT CONSISTENT, ASK THE RESPONDENT TO AVERAGE OUT HOW MANY HOURS PER MONTH AND THEN DIVIDE THIS BY 4.	AVERAGE HOURS PER WEEK WORKING IN THIS FACILITY ☐☐	
801	Now I would like to ask you some questions about supervision you have personally received. This supervision may have been from a supervisor either in this facility, or from outside the facility. Do you receive technical support or supervision in your work? IF YES, ASK: When was the most recent time?	YES, IN THE PAST 3 MONTHS. . . . . 1 YES, IN THE PAST 4-6 MONTHS. . . . . 2 YES, IN THE PAST 7-12 MONTHS. . . . . 3 YES, MORE THAN 12 MONTHS AGO. . . . . 4 NO. 5	→ 804
802	How many times in the past six months has your work been supervised?	NUMBER OF TIMES. . . . . ☐☐ EVERY DAY. . . . . '96	

			YES	NO	DK	
803	The last time you were personally supervised, did your supervisor do any of the following:					
01	Check your records or reports	CHECKED RECORD	1	2	8	
02	Observe your work	OBSERVED WORK	1	2	8	
03	Provide any feedback (either positive or negative) on your performance	FEEDBACK	1	2 → 05	8 → 05	
04	Give you verbal or written feedback that you were doing your work well	VERBAL PRAISE	1	2	8	
05	Provide updates on administrative or technical issues related to your work	PROVIDED UPDATES	1	2	8	
06	Discuss problems you have encountered	DISCUSSED PROBLEMS	1	2	8	

804	Do you have a written job description of your current job or position in this facility? IF YES, ASK: May I see it?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . 2 NO 3	
805	Are there any opportunities for promotion in your current job?	YES. . . . . 1 NO . . . . . 2 UNCERTAIN . . . . . 3 DON'T KNOW. 8	

808	Among the various things related to your working situation that you would like to see improved, can you tell me the three that you think would most improve your ability to provide good quality of care services? Please rank them in order of importance, with 1 being the most important. ENTER LETTER CORRESPONDING WITH THE 1ST MENTIONED INTO THE 1ST BOX, AND REPEAT WITH THE 2ND AND 3RD. IF THE PROVIDER ONLY MENTIONS 1 OR 2 ITEMS THEN PUT "Y" IN THE REMAINING BOX/ES. DO NOT LEAVE ANY BOX EMPTY. THERE MUST BE 3 ENTRY. DO NOT READ CHOICES TO YOUR RESPONDENT	MORE SUPPORT FROM SUPERVISOR. . . . . A MORE KNOWLEDGE / UPDATES TRAINING. . . . . B MORE SUPPLIES/STOCK. . . . . C BETTER QUALITY EQUIPMENT/ SUPPLIES. . . . . D LESS WORKLOAD (i.e. MORE STAFF). . . . . E BETTER WORKING HOURS / FLEXIBLE TIMES. . . . . F MORE INCENTIVES (SALARY, PROMOTION, HOLIDAYS). . . . . G TRANSPORTATION FOR REFERRAL PATIENTS. . . . . H PROVIDING ART. . . . . I PROVIDING PEP. . . . . J INCREASED SECURITY. . . . . K BETTER FACILITY INFRASTRUCTURE. . . . . L MORE AUTONOMY / INDEPENDENCE. . . . . M EMOTIONAL SUPPORT FOR STAFF (COUNSELING / SOCIAL ACTIVITIES). . . . . N OTHER (SPECIFY) _____. . . . X NO PROBLEM. . . . . Y	RANKING 
	THANK YOUR RESPONDENT AND MOVE TO THE NEXT DATA COLLECTION POINT	

Sample List for ANTENATAL CARE Observation

Date | | | | | **2** | **0** | **1** | |
DAY MONTH YEAR

| | | | | | FACILITY # |

TOTAL # OF ANC CLIENTS ON DAY OF VISIT FOR ALL PROVIDERS

USE THIS FORM TO LIST ANC CLIENTS SELECTED FOR ANC OBSERVATION FOR PROVIDER #1

	NAME/INITIALS	FIRST VISIT	FOLLOW-UP
101			
102			
103			
104			
105			
106			
107			
108			
109			
110			
111			
112			
113			
114			
115			
116			
117			
118			
119			
120			
121			
122			
123			
124			
125			

Sample List for ANTENATAL CARE Observation

Date DAY MONTH **2 0 1** YEAR

FACILITY #

USE THIS FORM TO LIST ANC CLIENTS SELECTED FOR ANC OBSERVATION FOR PROVIDER #2

	NAME/INITIALS	FIRST VISIT	FOLLOW-UP
126			
127			
128			
129			
130			
131			
132			
133			
134			
135			
136			
137			
138			
139			
140			
141			
142			
143			
144			
145			
146			
147			
148			
149			
150			

Sample List for ANTENATAL CARE Observation

Date | | | | | **2** | **0** | **1** | |
DAY MONTH YEAR

FACILITY #

USE THIS FORM TO LIST ANC CLIENTS SELECTED FOR ANC OBSERVATION FOR PROVIDER #3

	NAME/INITIALS	FIRST VISIT	FOLLOW-UP
151			
152			
153			
154			
155			
156			
157			
158			
159			
160			
161			
162			
163			
164			
165			
166			
167			
168			
169			
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172			
173			
174			
175			

NEPAL HEALTH FACILITY SURVEY - 2015

OBSERVATION OF ANC CONSULTATION

1. Facility Identification

QTYPE [O] [A] [N]

FACILITY NUMBER. . . . . [ ][ ][ ][ ][ ]

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM] . . . . . [ ][ ]

CLIENT CODE [FROM CLIENT LISTING FORM] . . . . . [ ][ ][ ]

2. Provider Information

Provider category:

GENERALIST MEDICAL DOCTOR (MDGP)	01
GYNECOLOGIST / OBSTESTRICIAN	02
ANESTHESIOLOGIST	03
PATHOLOGIST	04
GENERAL SURGEON	05
PEDIATRICIAN	06
OTHER SPECIALISTS MEDICAL DOCTORS	07
MEDICAL OFFICER (MBBS, BDS)	08
ANESTHETIC ASSISTANT	09
NURSE (MN, BSC NURSE, BN, PCL) / AUXILLARY NURSE MIDWIFE (ANM)	10
HEALTH ASSISTANT (HA) / AHW / SAHW / PUBLIC HEALTH INSPECTOR	12
OTHER CLINICAL STAFF NOT LISTED ABOVE	18
NON-CLINICAL STAFF/ NO TECHNICAL QUALIFICATION	95

PROVIDER CATEGORY [ ][ ]

SEX OF PROVIDER: (1=Male; 2=Female)

SEX OF PROVIDER . . . . . [ ]

3. Information About Observation

Date:. . . . .

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR 2015

Name of the observer: _____

OBSERVER CODE. . . . . [ ][ ][ ]

4. Observation of Antenatal-Care Consultation

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO

BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE CLIENT. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT AN "EXPERT" TO BE CONSULTED DURING THE SESSION.

	READ TO PROVIDER: Hello. I am [OBSERVER]. I am representing New ERA We are conducting a study of health facilities in Nepal with the goal of finding ways to improve the delivery of services. I would like to observe your consultation with this client in order to understand how ANC services are provided in this facility. Information from this observation is confidential. Neither your name nor that of the client will be recorded. The information acquired during this observation may be used by the MOH or other organizations to improve services, or for research on health services; however, neither your name nor the names of your clients will be entered in any database. Do you have any questions for me? If at any point you feel uncomfortable you can ask me to leave. However, we hope you won't mind our observing your consultation. Do I have your permission to be present at this consultation? _____ Interviewer's signature (Indicates respondent's willingness to participate) DAY __ __ MONTH __ __ YEAR 2 0 1 _		
100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**

	READ TO CLIENT: Hello, I am_____. I am representing New ERA We are conducting a study of health services in Nepal. I would like to be present while you are receiving services today in order to understand how ANC services are provided in this facility. We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. And although information from this observation may be provided to researchers for analyses, neither your name nor the date of service will be provided in any shared data, so your identity and any information about you will remain completely confidential. Please know that whether you decide to allow me to observe your visit is completely voluntary and that whether you agree to participate or not will not affect the services you receive. If at any point you would prefer I leave please feel free to tell me. After the consultation, my colleague would like to talk with you about your experience here today. Do you have any questions for me at this time? Do I have your permission to be present at this consultation? _____ Interviewer's signature (Indicates respondent's willingness to participate)		
101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CLIENT.	YES . . . . . 1 NO 2	→ **END**
102*	RECORD THE TIME THE OBSERVATION STARTED . . . . . . USE 24 HOURS FORMAT	__ __ : __ __	
103	IS THIS THE FIRST OBSERVATION FOR THIS PROVIDER FOR THIS SERVICE?	YES . . . . . 1 NO 2	

NO.	QUESTION / OBSERVATIONS	CODES
FOR EACH OF THE GROUPS THAT FOLLOW, CIRCLE ANY ACTION TAKEN BY THE PROVIDER OR THE CLIENT. IF NO ACTION IN THE GROUP IS OBSERVED, CIRCLE "Y" FOR EACH GROUP AT THE END OF THE OBSERVATION.		

CLIENT HISTORY : GENERAL

104	RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FACTS:	
01	Client's age	A
02	Medications the client is taking	B
03	Date client's last menstrual period began	C
04	Number of prior pregnancies client has had	D
05	None of the above	Y

CLINICAL HISTORY: ASPECTS OF PRIOR PREGNANCIES

105*	RECORD WHETHER THE PROVIDER OR THE CLIENT DISCUSSED ANY OF THE FOLLOWING ASPECTS OF THE CLIENT'S PRIOR PREGNANCIES:	
01	Prior stillbirth(s)	A
02*	New born who died in the first week of life	B
03*	Heavy bleeding during delivery	C
04*	Previous assisted vaginal delivery / Instrumental delivery	D
05	Previous spontaneous abortions	E
06	Previous multiple pregnancies	F
07	Previous prolonged labor	G
08*	Previous pregnancy-induced hypertension (Pre-eclampsia)	H
09*	Previous pregnancy related convulsions (Eclampsia)	I
10	High fever or infection during prior pregnancy/pregnancies	J
11	Caesarean section	K
12	Gestational diabetes	L
13	Birth defects in the last birth (congenital defect/anomalies)	M
14*	Heavy bleeding after delivery	N
15*	High fever or infection during post partum	O
16*	Previous induced abortion	P
17*	Any bleeding during pregnancy	Q
18*	None of the above	Y

NO.	QUESTION / OBSERVATIONS	CODES

CLINICAL HISTORY: ASPECT OF CURRENT PREGNANCY

106*	IN **COLUMN A**, RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FOR CURRENT PREGNANCY. IN **COLUMN B**, RECORD WHETHER THE PROVIDER COUNSELLED ON THE DANGER SIGNS	(A) PROVIDER ASKED ABOUT OR CLIENT MENTIONED	(B) PROVIDER DISCUSSED OR MANAGED
01	Vaginal bleeding	A	A
02	Fever	B	B
03	Headache or blurred vision	C	C
04	Swollen face or hands or extremities	D	D
05	Tiredness or breathlessness	E	E
06	Fetal movement (loss of, excessive, normal)	F	F
07*	Cough for 3 weeks or longer	G	G
08	Any other symptoms or problems the client thinks might be related to this pregnancy	H	H
09*	Lower abdominal pain	I	I
10*	Vaginal discharge	J	J
11	None of the above	Y	Y

PHYSICAL EXAMINATION

107*	RECORD WHETHER THE PROVIDER PERFORMED THE FOLLOWING PROCEDURES:	
01	Take the client's blood pressure	A
02	Weigh the client	B
03	Examine conjunctiva/palms for anemia	C
04	Examine legs/feet/hands for edema	D
05	Examine for swollen glands or lymphnodes	E
06	Examine the client's breasts	J
07*	Palpate the client's abdomen for uterine height / Fundal height using tape measure	G
08	Palpate the client's abdomen for fetal presentation	F
09	Listen to the client's abdomen for fetal heartbeat	H
10	Conduct an ultrasound/refer client for ultrasound/look at recent ultrasound report	I
11	Conduct vaginal examination/exam of perineal area	K
13	None of the above	Y

NO.	QUESTION / OBSERVATIONS	CODES

ROUTINE TESTS

108	RECORD WHETHER THE PROVIDER A) ASKED ABOUT, B) PERFORMED OR, C) REFERRED THE CLIENT FOR THE FOLLOWING TESTS	(A) PROVIDER ASKED	(B) PROVIDER PERFORMED	(C) PROVIDER REFERRED	D* PROVIDER LOOKED AT REPORT	(Y) NO ACTION TAKEN
01	Hemoglobin test	A	B	C	D	Y
02	Blood grouping	A	B	C	D	Y
03	Any urine test	A	B	C	D	Y
04	Syphilis test	A	B	C	D	Y

HIV TESTING AND COUNSELLING

109	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING:	
01	Asked if the client knew her HIV status	A
02	Provide counseling related to HIV test	B
03	Refer for counseling related to HIV test	C
04	Perform HIV test	D
05	Refer for HIV test	E
06	None of the above	Y

MAINTAINING A HEALTHY PREGNANCY

110	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING ADVICE OR COUNSEL ABOUT PREPARATIONS	
01	Discussed nutrition (i.e., quantity or quality of food to eat) during the pregnancy	A
02	Informed the client about the progress of the pregnancy	B
03	Discussed the importance of at least 4 ANC visits	C
04	None of the above	Y

IRON PROPHYLAXIS

111*	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENT OR COUNSELLING:	
01	Prescribed or gave iron pills or folic acid (IFA) or both	A
02	Explained the purpose of iron or folic acid	B
03	Explained how to take iron or folic-acid pills	C
04	Explained side effects of iron pills	D
06	None of the above	Y

TETANUS DIPHTERIA TOXOID INJECTION

112*	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENT OR COUNSELLING:	
01	Prescribed or gave a tetanus diphteria toxoid (Td) injection	A
02	Explained the purpose of the a tetanus diphteria toxoid (Td) injection	B
04	None of the above	Y

NO.	QUESTION / OBSERVATIONS	CODES

DEWORMING

113*	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENTS	
01	Prescribed or gave Mebendazole/Albendazole	A
02	Explained the purpose of Mebendazole/Albendazole	B
04	None of the above	Y

MALARIA

114*	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENT OR COUNSELLING:	
01*	Provider identified need to provide client with an LLIN by asking if client had an LLIN or is currently using an LLIN	J
02*	Provided LLIN to client as part of consultation or instructed client to obtain LLIN elsewhere in facility	F
03*	Explicitly explained importance of using LLIN to client	G
04	None of the above	Y

PREPARATION FOR DELIVERY

115*	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELLED ABOUT DELIVERY IN ANY OF THE FOLLOWING WAYS:	
02*	Asked the client where she will deliver and advised the client to prepare for delivery (e.g. set aside money, arrange for emergency transportation, identify blood donor,)	B
03*	Advised the client to use a skilled birth attendant, go to the health facility	C
04*	Discussed with client what items to have on hand at home (e.g., blade, clean delivery kit, misoprostol, 7.1% Chlorexidine)	D
06	None of the above	Y

ESSENTIAL NEWBORN CARE AND POSTPARTUM RECOMMENDATIONS

116*	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELLED ABOUT NEWBORN OR POSTPARTUM CARE IN ANY OF THE FOLLOWING WAYS:	
01	Discussed care for the newborn (i.e., warmth, hygiene and cord care, delay bathing for at least 24 hours after birth)	A
02	Discussed immediat breastfeeding initiation	B
03	Discussed exclusive breastfeeding	C
04	Discussed importance of vaccination for the newborn	D
05	Discussed family planning options for after delivery	E
06	None of the above	Y

NO.	QUESTION / OBSERVATIONS	CODES

DANGER SIGNS DURING PREGNANCY

116A*	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELLED ABOUT ANY OF THE FOLLOWING DANGER SIGNS DURING PREGNANCY:	
01	Severe headache	A
02	Blurred vision	B
03	Severe lower abdominal pain	C
04	Swelling of hand , body or face	D
05	Convulsion / unconsciousness	E
06	Any vaginal spotting or bleeding	F
08	None of the above	Y

DANGER SIGNS DURING LABOR & DELIVERY

116B*	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELLED ABOUT ANY OF THE FOLLOWING DANGER SIGNS DURING DELIVERY:	
01	Labor pain longer than 8hours duration	A
02	Appearance of baby's hand, leg and placenta first	B
03	Convulsion / unconsciousness	C
04	Excessive bleeding before or after delivery	D
08	None of the above	Y

DANGER SIGNS OF NEWBORN

116C*	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELLED ABOUT ANY OF THE FOLLOWING DANGER SIGNS OF NEWBORN:	
01	Not able to suck breast	A
02	Lethargic or unconscious	B
03	Fast breathing	C
04	Severe chest indrawing	D
05	Fever	E
06	Hypothermia	F
07	10 or more than 10 skin pustule or 1 abscess	G
08	Umbilical infection	H
09	None of the above	Y

DANGER SIGNS IN POSTPARTUM PERIOD

116D*	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELLED ABOUT ANY OF THE FOLLOWING DANGER SIGNS IN POSTPARTUM PERIOD:	
01	Fever	A
02	Pain in lower abdominal or foul smelling discharge	B
03	Excessive bleeding	C
04	Severe headache	D
05	Convulsion / unconsciousness	E
08	None of the above	Y

NO.	QUESTION / OBSERVATIONS	CODES

OVERALL OBSERVATIONS OF INTERACTION

117	RECORD WHETHER THE PROVIDER ASKED IF THE CLIENT HAD ANY QUESTIONS AND ENCOURAGED QUESTIONS.	YES, ASKED QUESTIONS. . . . . 1 NO, DID NOT ASK QUESTIONS. 2	
118	RECORD WHETHER THE PROVIDER USED ANY VISUAL AIDS FOR HEALTH EDUCATION OR COUNSELLING DURING THE CONSULTATION.	YES, USED VISUAL AIDS. . . . . 1 NO AIDS USED. 2	
119	RECORD WHETHER THE PROVIDER LOOKED AT THE CLIENT'S MATERNAL & NEW BORN HEALTH CARD (MNH CARD, HMIS 3.5) OR ANY CLIENT'S HEALTH CARD (EITHER BEFORE BEGINNING THE EXAMINATION, WHILE COLLECTING INFORMATION OR EXAMINING THE CLIENT).	YES, LOOKED AT CARD. . . . . 1 NO, DID NOT LOOK AT CARD. . . . . 2 NO HEALTH CARD USED. . . . . 3 →	121
120*	RECORD WHETHER THE PROVIDER WROTE ON THE CLIENT'S MNH CARD (HMIS 3.5). OR ANY CLIENT'S HEALTH CARD	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
120A	RECORD WHETHER ANY ON-TH-JOB TRAINING NURSE OR NURSES PARTICIPATED IN THE PROVISION OF CARE TO THIS CLIENT. THEY MAY PARTICIPATE BY TAKING CERTAIN MEASUREMENTS OR PALPATING CLIENTS ABDOMEN	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
121	RECORD THE OUTCOME OF THE CONSULTATION. [RECORD THE OUTCOME AT THE TIME THE OBSERVATION CONCLUDED]	CLIENT GOES HOME. . . . . 1 CLIENT REFERRED TO OTHER PROVIDER AT SAME FACILITY. . . . . 2 CLIENT ADMITTED TO SAME FACILITY. . . . . 3 CLIENT REFERRED TO OTHER FACILITY. . . . . 4 CLIENT REFERRED TO LAB. 5	

QUESTIONS TO CONFIRM WITH ANC PROVIDER

	ASK THE PROVIDER THE FOLLOWING QUESTIONS AND VERIFY IN THE ANC REGISTER OR ON CLIENT'S MNH CARD (HMIS 3.5) OR ANY CLIENT'S HEALTH CARD		
122	How many weeks pregnant is the client?	WEEKS OF PREGNANCY . . . . . ☐☐	
123	Is this the client's 1st, 2nd, 3rd, 4th or 5th visit for antenatal care **at this facility for this pregnancy**?	FIRST VISIT. . . . . 1 SECOND VISIT. . . . . 2 THIRD VISIT. . . . . 3 FOURTH VISIT. . . . . 4 FIFTH OR MORE VISIT. . . . . 5 DON'T KNOW. 8	
124	Has the client had a previous pregnancy, regardless of the duration or outcome of that pregnancy, or is this the client's first pregnancy?	FIRST PREGNANCY. . . . . 1 NOT FIRST PREGNANCY. . . . . 2 DON'T KNOW. 8	
125*	RECORD THE TIME THE OBSERVATION ENDED. . . . . ☐☐ : ☐☐ USE 24 HOURS FORMAT		
	Observer's comments:		

NEPAL HEALTH FACILITY SURVEY - 2015

ANC CLIENT EXIT INTERVIEW

FACILITY IDENTIFICATION

FACILITY NUMBER . . . . . | | | | | |

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM]. . . . . | | |

CLIENT CODE [FROM CLIENT LISTING FORM] . . . . . | | |

INFORMATION ABOUT INTERVIEW

DATE:. . . . . .

DAY . . . . . | | |

MONTH . . . . . | | |

YEAR 2015

Name of the interviewer: _____

INTERVIEWER CODE. . . . . | | |

1. Information About Visit - ANTENATAL CARE

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	READ TO CLIENT: Hello, I am_____. As my colleague mentioned, we are representing New ERA. We are conducting a study of health facilities in Nepal in order to improve the services this facility offers and would like to ask you some questions about your experiences here today. Please know that whether you decide to allow this interview or not is completely voluntary and will not affect services you receive during any future visit. You may refuse to answer any question, and you may stop the interview at any time. Information from this interview may be provided to researchers for analyses, but neither your name nor the date of services will be on any shared information, so your identity will remain completely confidential. Do you have any questions for me? Do I have your permission to continue with the interview? _____ Interviewer's signature (Indicates respondent's willingness to participate) DAY | MONTH | YEAR: __ | __ | 2 0 1 _		
100	May I begin the interview now?	AGREES . . . . . 1 CLIENT REFUSES 2	→ **END**
101*	RECORD THE TIME THE INTERVIEW STARTED. USE 24 HOURS FORMAT	. . . . . __ . __	
102*	Do you have a maternal & newborn health (MNH) card (HMIS 3.5) or any health card with you today? IF YES: ASK TO SEE THE CARD/BOOK.	YES . . . . . 1 NO, CARD KEPT WITH FACILITY . . . . . 2 NO CARD/BOOK USED 3	→106
103*	CHECK THE MNH CARD OR ANY HEALTH CARD INDICATE WHETHER THERE IS ANY NOTE OR RECORD OF THE CLIENT HAVING RECEIVED TETANUS DIPHTERIA TOXOID.	YES, 1 TIME. . . . . 1 YES, 2 TIMES. . . . . 2 YES, 3 OR MORE TIMES. . . . . 3 NO RECORD. 4	
104*	HOW MANY WEEKS PREGNANT IS THE CLIENT, ACCORDING TO THE MNH CARD OR ANY CLIENT'S HEALTH CARD?	# OF WEEKS. . . . . __ NOT AVAILABLE. 95	
106	Have you ever been pregnant, regardless of the duration or outcome, or is this your first pregnancy?	FIRST PREGNANCY. . . . . 1 NOT FIRST PREGNANCY. 2	
107	Is this your first antenatal visit at this facility for this pregnancy? IF THIS IS NOT THE 1ST VISIT, ASK: How many times have you visited this antenatal clinic for this pregnancy?	FIRST VISIT . . . . . 1 SECOND VISIT . . . . . 2 THIRD VISIT . . . . . 3 FOURTH VISIT . . . . . 4 MORE THAN 4 VISITS 5	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
108*	During this visit (or previous visits) did a provider give you iron pills, folic acid or iron with folic acid? SHOW THE CLIENT AN IRON PILL, A FOLIC-ACID PILL, OR A COMBINED PILL.	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	→ 109
108A	During this visit (or previous visits) did a provider give you a prescription for iron pills, folic acid or iron with folic acid?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	→ 114
109	During this visit (or previous visits) has a provider explained to you how to take the iron pills?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	
110*	During this visit (or previous visits) did a provider discuss with you the side effects of the iron pill?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	
111	Please tell me any side effects of the iron pill that you know of. PROBE: ANY OTHER?	NAUSEA . . . . . A BLACK STOOLS . . . . . B CONSTIPATION . . . . . C OTHER_____ X DON'T KNOW . . . . . Z	
114	During this visit (or a previous visit) did a provider advice you to use mosquito net that has been treated with an insecticide?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	
115*	During this visit (or a previous visit) did a provider offer you a mosquito net that has been treated with an insecticide free of charge?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	
117	During this visit (or previous visits) has a provider talked to you about nutrition or what is good for you to be eating during your pregnancy?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	
118*	Please tell me any signs of complications or danger signs of pregnancy that you know of. I am referring to anything that could be an indication of a problem or complication with the pregancy, or anything that could negatively affect the pregnancy. CIRCLE ALL RESPONSES CLIENT MENTIONS. YOU MAY PROBE WITHOUT USING SPECIFIC ANSWERS GIVEN ON RIGHT (E.G., "ANYTHING ELSE?")	VAGINAL BLEEDING. . . . . A FEVER. . . . . B SWOLLEN FACE OR HAND OR EXTREMITIES . . . . . C TIREDNESS OR BREATHLESSNESS. . . . . D HEADACHE OR BLURRED VISION. . . . . E SEIZURES/CONVULSIONS. . . . . F REDUCED OR ABSENCE OF FETAL MOVEMENT. . . . . G LOWER ABDOMINAL PAIN H OTHER. . . . . X DON'T KNOW ANY. . . . . Z	→ 120

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
119	During this visit or previous visits, has a provider talked with you about any signs that should warn you of problems or complications with the pregnancy?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	
120	What did the provider advise you to do if you experienced any of the signs of complications? CIRCLE LETTER FOR ALL COURSES OF ACTION THE CLIENT MENTIONS. PROBE WITHOUT USING SPECIFIC ANSWERS.	SEEK CARE AT A FACILITY. . . . . A REDUCE PHYSICAL ACTIVITY. . . . B CHANGE DIET. . . . . C OTHER_____ X (SPECIFY) PROVIDER DID NOT ADVISE. . . . Y	
121	During this visit (or previous visits) has a provider discussed things you should have in preparation for this delivery? This may include planning in case of emergency, things you should bring to a facility, or things you should prepare at home for this delivery.	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . . 2 YES PREVIOUS VISIT ONLY. . . . . 3 NO. . . . . 4 DON'T KNOW ANY. 8	
122*	Please tell me some of the things you know of that you should have in preparation for the delivery. CIRCLE ALL RESPONSES YOU MAY PROBE WITHOUT USING SPECIFIC ANSWERS GIVEN ON RIGHT (E.G., "ANYTHING ELSE?")	EMERGENCY TRANSPORT. . . . A MONEY. . . . . B DISINFECTANT. . . . . C CLEAN DELIVERY KIT G IDENTIFICATION OF SKILLED BIRTH ATTENDANT H IDENTIFICATION OF POSSIBLE BLOOD DONOR I CLEAN CLOTH FOR BABY J OTHER_____. . . . . X DON'T KNOW . . . . . Z	
123*	Do you have money set aside for any emergencies? IF YES, ASK: Do you think you have enough?	YES, ENOUGH . . . . . 1 YES, BUT NOT ENOUGH . . . . . 2 NO 3	
124	During this visit (or previous visits) did a provider talk to you about where you plan to deliver your baby?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
125	Have you decided where you will go for the delivery of your baby? IF YES PROBE FOR WHETHER THE PLAN IS TO DELIVER IN A FACILITY OR AT HOME.	AT THIS HEALTH FACILITY. . . . . 1 OTHER HEALTH FACILITY. . . . 2 AT HOME. . . . . 3 AT TBA's HOME. . . . . 4 OTHER LOCATION_____ 6 NO/DON'T KNOW. 8	
126*	Do you know any complications during or immediately after childbirth? IF YES: What danger signs do you know?	EXCESSIVE BLEEDING. . . . . A FEVER. . . . . B GENITAL INJURIES. . . . . C PERINEAL PAIN. . . . . D URINARY RETENTION. . . . . E OTHER_____ X (SPECIFY) NO. . . . . Y	
127	During this visit (or previous visits) has a provider given you advice on the importance of exclusively breastfeeding—that is, about giving your baby nothing apart from breast milk for a specific period of time?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . . 3 NO. . . . . 4 DON'T KNOW. 8	→129
128	For how many months did the provider recommend that you exclusively breastfeed, that is, that you do not give your baby any fluids or food in addition to breast milk?	BETWEEN 4 TO 6 MONTHS. . . . . 1 6 MONTHS. . . . . 2 OTHER. . . . . 6 DON'T KNOW 8	
129*	During this visit (or previous visits) did a provider talk with you about using family planning after the birth of your baby?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	
129A	During this visit (or previous visits) did a provider talk with you about immediate breastfeeding initiation within 1 hour of the birth of your baby?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . . 3 NO. . . . . 4 DON'T KNOW. 8	

2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
Now I am going to ask you some questions about the services you received today. I would like to have your honest opinion about the things that we will talk about. This information will help improve services in general.			
201	How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation? TRY TO DETERMINE THE TIME THE CLIENT ARRIVED AT THE FACILITY AND WHEN THE FACILITY OPENS FOR SERVICES. WE ARE INTERESTED IN THE WAITING TIME FROM THE TIME THE FACILITY OFFICIALLY OPENS	MINUTES . . . . . [ ][ ][ ] SAW PROVIDER IMMEDIATELY . . . . . 000 DON'T KNOW 998	

202 Now I am going to ask about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were **major** or **minor** problems for you.

		MAJOR	MINOR	NO PROB-LEM	DK
01	Time you waited to see a provider	1	2	3	8
02	Ability to discuss problems or concerns about your pregnancy	1	2	3	8
03	Amount of explanation you received about the problem or treatment	1	2	3	8
04	Privacy from having others see the examination	1	2	3	8
05	Privacy from having others hear your consultation discussion	1	2	3	8
06	Availability of medicines at this facility	1	2	3	8
07	The hours of service at this facility, i.e., when they open and close	1	2	3	8
08	The number of days services are available to you	1	2	3	8
09	The cleanliness of the facility	1	2	3	8
10	How the staff treated you	1	2	3	8
11	Cost for services or treatments	1	2	3	8

204	Were you charged, or did you pay fees for any services your received or were provided today?	YES . . . . . 1 NO 2	→ 206

205	What is the total amount you paid for all services or treatments you received at this facility today?	TOTAL AMOUNT ☐☐☐☐☐☐ DON'T KNOW 999998	
206	Is this the closest health facility to your home?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	→ 208 → 208
207	What was the main reason you did not go to the facility nearest to your home? IF CLIENT MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE PERSONNEL . . .03 NO MEDICINE . . . . . .04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . . 06 WAS REFERRED . . . . . .07 OTHER. . . . . 96 DON'T KNOW 98	
208	In general, which of the following statements best describes your opinion of the services you either received or were provided at this facility today: READ ALL STATEMENTS, CIRCLE ONLY ONE 01): I AM **VERY SATISFIED** WITH THE SERVICES I RECEIVED TODAY. . . . . 1 02): I AM **FAIRLY SATISFIED** WITH THE SERVICES I RECEIVED TODAY. . . . . 2 03): I AM **NEITHER SATISFIED NOR DISSATISFIED** (NEUTRAL) WITH THE SERVICES I RECEIVED TODAY. . . . . 3 04): I AM **FAIRLY DISSATISFIED** WITH THE SERVICES I RECEIVED TODAY. . . . . 4 05): I AM **VERY DISSATISFIED** WITH THE SERVICES I RECEIVED IN FACILITY. . . . 5		
209	Will you recommend this health facility to a friend or family member?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

3. Client Personal Characteristics

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
Now I am going to ask you some questions about yourself. I would like to have your honest responses as this information will help to improve services in general.			
302	How old were you at your last birthday?	AGE IN YEARS . . . . . ☐☐ DON'T KNOW. 98	
303	Have you ever attended school?	YES . . . . . 1 NO 2	→ 304C
304A	What is the highest grade you completed? IF COMPLETED LESS THAN ONE GRADE, RECORD "00" *CODES FOR GRADES 00 = NOT PASSED GRADE I 01-09 = GRADE 1 TO 9 PASSED 10 = SLC PASSED 11 = PASSED PROFICIENCY CERTIFICATE 12 = PASSED BACHELOR DEGREE 13 = PASSED MASTER OT HIGHER DEGREE	GRADE . . . . . ☐☐	
304B	CHECK Q304A GRADE 5 OR LOWER ☐ GRADE 6 OR HIGHER ☐ → 305A		
304C	Now I would like you to read this sentence to me. SHOW CARD TO RESPONDENT. IF RESPONDENT CANNOT READ WHOLE SENTENCE, PROBE: Can you read any part of the sentence to me?	YES, CANNOT READ AT ALL 1 ABLE TO READ ONLY PARTS OF SENTENCE . . . . . 2 ABLE TO READ WHOLE SENTENCE. . . . . 3 NO CARD WITH REQUIRED LANGUAGE_____ 4 (SPECIFY LANGUAGE) BLIND/VISUALLY IMPAIRED. . . . 5	
305A*	What isyour caste/ethnicity?	BRAHMIN / CHHETTRI. . . . . 01 TERAI MADHESI OTHER CASTES. . . . . 02 DALIT. . . . . 03 NEWAR. . . . . 04 JANJATI. . . . . 05 MUSLIM. . . . . 06 OTHER CATEGORY. 96	
306*	RECORD THE TIME THE INTERVIEW ENDED USE 24 HOURS FORMAT	☐☐ : ☐☐	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		

Interviewer's comments:

Sample List for FAMILY PLANNING Observation

Date | | | | | **2** | **0** | **1** | |
DAY MONTH YEAR

| | | | | | FACILITY # |

TOTAL # OF FP CLIENTS ON DAY OF VISIT FOR ALL PROVIDERS | | | |

USE THIS FORM TO LIST FP CLIENTS SELECTED FOR FP OBSERVATION FOR PROVIDER #1

	NAME/INITIALS	FIRST VISIT	FOLLOW-UP
201			
202			
203			
204			
205			
206			
207			
208			
209			
210			
211			
212			
213			
214			
215			
216			
217			
218			
219			
220			
221			
222			
223			
224			
225			

Sample List for FAMILY PLANNING Observation

Date | | | | | **2** | **0** | **1** | | DAY MONTH YEAR

| | | | | | FACILITY #

USE THIS FORM TO LIST FP CLIENTS SELECTED FOR FP OBSERVATION FOR PROVIDER #2

	NAME/INITIALS	FIRST VISIT	FOLLOW-UP
226			
227			
228			
229			
230			
231			
232			
233			
234			
235			
236			
237			
238			
239			
240			
241			
242			
243			
244			
245			
246			
247			
248			
249			
250			

Sample List for FAMILY PLANNING Observation

Date | | | | | **2** | **0** | **1** | |
DAY MONTH YEAR

			FACILITY #

USE THIS FORM TO LIST FP CLIENTS SELECTED FOR FP OBSERVATION FOR PROVIDER #3

	NAME/INITIALS	FIRST VISIT	FOLLOW-UP
251			
252			
253			
254			
255			
256			
257			
258			
259			
260			
261			
262			
263			
264			
265			
266			
267			
268			
269			
270			
271			
272			
273			
274			
275			

Nepal Health Facility Survey 2015

OBSERVATION OF FAMILY PLANNING CONSULTATION

1. Facility Identification

QTYPE [O] [F] [P]

FACILITY NUMBER. . . . . [ ][ ][ ][ ][ ]

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM] . . . . . [ ][ ]

CLIENT CODE [FROM CLIENT LISTING FORM] . . . . . [ ][ ][ ]

2. Provider Information

Provider category:

GENERALIST MEDICAL DOCTOR (MDGP).	01
GYNECOLOGIST / OBSTETRICIAN	02
ANESTHESIOLOGIST	03
PATHOLOGIST	04
GENERAL SURGEON	05
PEDIATRICIAN	06
OTHER SPECIALISTS MEDICAL DOCTORS	07
MEDICAL OFFICER (MBBS, BDS)	08
ANESTHETIC ASSISTANT.	09
NURSE (MN, BSC NURSE, BN, PCL) / AUXILLARY NURSE MIDWIFE (ANM).	10
HEALTH ASSISTANT (HA) / AHW / SAHW / PUBLIC HEALTH INSPECTOR	12
OTHER CLINICAL STAFF NOT LISTED ABOVE	18
NON-CLINICAL STAFF / NO TECHNICAL QUALIFICATION.	95

PROVIDER CATEGORY [ ][ ]

SEX OF PROVIDER: (1=Male; 2=Female)

SEX OF PROVIDER . . . . . [ ]

3. Information About Observation

Date:. . . . .

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR 2015

Name of the observer: _____

OBSERVER CODE. . . . . [ ][ ][ ]

4. Observation of Family Planning Consultation

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO

BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE CLIENT. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT AN "EXPERT" TO BE CONSULTED DURING THE SESSION.

READ TO PROVIDER: Hello. I am [OBSERVER]. I am representing New ERA
We are conducting a study of health facilities in Nepal with the goal of finding ways to improve the delivery of services. I would like to observe your consultation with this client in order to understand how family planning services are provided in this facility.

Information from this observation is confidential. Neither your name nor that of the client will be recorded. The information acquired during this observation may be used by the MOH or other organizations to improve services, or for research on health services; however, neither your name nor the names of your clients will be entered in any database.

Do you have any questions for me? If at any point you feel uncomfortable you can ask me to leave. However, we hope you won't mind our observing your consultation.

Do I have your permission to be present at this consultation?

Interviewer's signature
(Indicates respondent's willingness to participate)

DAY ____ MONTH ____ YEAR 2015

100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**

READ TO CLIENT: Hello, I am_____. I am representing New ERA
We are conducting a study of health services in Nepal. I would like to be present while you are receiving services today in order to understand how family planning services are provided in this facility.

We are not evaluating the [PROVIDER] or the facility. And although information from this observation may be provided to researchers for analyses, neither your name nor the date of services will be provided in any shared data, so your identity and any information about you will remain completely confidential.

Please know that whether you decide to allow me to observe your visit is completely voluntary and that whether you agree to participate or not will not affect the services you receive. If at any point you would prefer I leave please feel free to tell me.

After the consultation, my colleague would like to talk with you about your experience here today. Do you have any questions for me at this time? Do I have your permission to be present at this consultation?

101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CLIENT.	YES . . . . . 1 NO 2	→ **END**
102*	RECORD THE TIME THE OBSERVATION STARTED. . . . . . USE 24 HOURS FORMAT	___ : ___	
103	IS THIS THE FIRST OBSERVATION FOR THIS PROVIDER FOR THIS SERVICE?	YES . . . . . 1 NO 2	
104	RECORD THE SEX OF CLIENT.	MALE . . . . . 1 FEMALE 2	

NO.	QUESTIONS / OBSERVATIONS	CODES

CLIENT HISTORY (FEMALE CLIENTS ONLY)

105	INDICATE BELOW WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT VOLUNTEERED INFORMATION ON THE FOLLOWING ITEMS:	
01	Last delivery date or age of youngest child	A
02	Last menstrual period (to assess if currently pregnant)	B
03	Breastfeeding status	C
04	Regularity of menstrual cycle	D
05	None of the above	Y

CLIENT HISTORY (ALL CLIENTS)

106	CLIENT'S PERSONAL INFORMATION AND REPRODUCTIVE HISTORY. INDICATE BELOW WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT VOLUNTEERED INFORMATION ON THE FOLLOWING ITEMS:	
01	Age of client	A
02	Number of living children	B
03	Desire for a child or more children	C
04	Desired timing for birth of next child	D
05*	Asked the client about his/her smoking habits	E
06*	Asked the client about symptoms of STIs (e.g., abnormal vaginal/urethral discharge)	F
07*	Asked the client about any chronic illnesses (e.g., heart disease, diabetes, hypertension, liver disease, or breast cancer)	G
08	None of the above	Y

PHYSICAL EXAMINATION

107	RECORD WHETHER THE PROVIDER PERFORMED ANY OF THE FOLLOWING PHYSICAL EXAMINATIONS OR ASKED ANY OF THE FOLLOWING HEALTH QUESTIONS:	
01	Took the client's blood pressure	A
02	Weighed the client	B
06	None of the above	Y

PARTNER AND STIS

108	RECORD WHETHER THE PROVIDER DISCUSSED ANY OF THE FOLLOWING ISSUES RELATED TO SEXUAL PARTNERS AND CHOICE OF FAMILY PLANNING METHOD.	
01	Partner's attitude toward family planning (in favor of, or against idea of family planning)	A
02	Partner status (number of client's sexual partners, or of client's partner; periods of partner's absence)	B
03	Client's perceived risk of STIs/HIV	C
04	Use of condoms to prevent STIs/HIV	D
05	Using condoms along with another method (dual method) to prevent both pregnancy and STIs/HIV	E
06	None of the above	Y

NO.	QUESTIONS / OBSERVATIONS	CODES

QUESTIONS/CONCERNS

109	RECORD WHETHER THE PROVIDER OR CLIENT DID ANY OF THE FOLLOWING	
01	Provider asked client if he/she had questions or concerns regarding current method or past method	A
02	Client expressed concerns about method (past or current), or asked questions about method (past or current), including possible side effects of method	B
03	None of the above	Y

PRIVACY/CONFIDENTIALITY

110	RECORD WHETHER THE PROVIDER TOOK ANY OF THE FOLLOWING STEPS TO ASSURE THE CLIENT OF PRIVACY	
01	Ensured visual privacy	A
02	Ensured auditory privacy	B
03	Assured the client orally of confidentiality	C
04	None of the above	Y

METHODS PROVIDED OR PRESCRIBED

111* **VERIFY METHOD WITH PROVIDER AND INDICATE WHICH METHOD(S) WERE EITHER** PROVIDED OR PRESCRIBED DURING THIS VISIT. IF CONDOMS WERE EITHER PRESCRIBED OR PROVIDED FOR USE ALONG WITH ANOTHER METHOD, CIRCLE BOTH METHODS.

IF CLIENT IS CONTINUING CLIENT WHO RECEIVED REFILLS FOR PILLS, REPEAT INJECTION, OR REPLACEMENT FOR IUCD DURING THIS VISIT, CIRCLE THE METHOD THAT WAS REPLENISHED IN COLUMN B.

IN COLUMN C, CIRCLE ALL METHODS THAT WERE DISCUSSED AS PART OF THE VISIT

CAUTION!

AT LEAST ONE RESPONSE MUST BE REPORTED FOR EACH OF THE COLUNMS

IF NO METHOD IS PRECRIBED, THEN "Y" SHOULD BE CIRCLED IN COLUMN "A"

	METHOD	(A) PRESCRIBED TO BE FILLED LATER OR AT A DIFFERENT LOCATION	(B) PROVIDED TO CLIENT IN FACILITY	(C) DISCUSSED AS PART OF VISIT
01	COMBINED ORAL PILL (OCP)	A	A	A
02	PROGESTIN-ONLY ORAL PILL	B	B	B
03	ORAL PILL (TYPE UNSPECIFIED)	C	C	C
04	PROGESTIN-ONLY INJECTABLE (2 OR 3-MONTHLY) DEPO	E	E	E
05	MALE CONDOM	F	F	F
06	IUCD (COPPER-T)	H	H	H
07	IMPLANT (ZEDEL OR INDOPLANT)	I	I	I
08	EMERGENCY CONTRACEPTIVE PILLS (ECP)	J	J	J
09	COUNSELING ON PERIODIC ABSTINENCE		L	L
10	VASECTOMY (MALE STERILIZATION)	M	M	M
11	TUBAL LIGATION (FEMALE STERILIZATION)	N	N	N
12	COUNSELING ON LACTATIONAL AMENORHEA		O	O
13*	OTHER (E.G., VAGINAL PESSARIES)	X	X	X
14	NO METHOD	Y	Y	Y

NO.	QUESTIONS / OBSERVATIONS	CODES
	FOR Q112-129, CIRCLE THE APPROPRIATE LETTERS TO INDICATE IF THE INFORMATION UNDER EACH RELEVANT SECTION WAS DISCUSSED OR SHARED WITH THE CLIENT.	
112*	CHECK Q111: ARE "A", "B", "C" OR "E" CIRCLED IN EITHER COLUMNS "A" OR "B" OR IN BOTH COLUMNS "A" AND "B"? YES ☐ NO ☐ →	114
113	**PILLS OR INJECTIONS**	
01	When to take (pill daily; injection either every month or every 2 or 3 months)	A
02	Changes that may occur with menstruation (decreased flow or amenorrhea, spotting)	B
03	Initial side effects that may occur (such as nausea, weight gain, and breast tenderness)	C
04	What to do if forget pill or do not get injection on time	D
05	Method does not protect against STIs, including HIV	E
06	Should return to clinic if side effects appear or persist	F
07	None of the above	Y
114*	CHECK Q111: IS "F" CIRCLED IN EITHER COLUMN "A" OR "B" OR IN BOTH COLUMNS "A" AND "B"? YES ☐ NO ☐ →	116
115	**CONDOMS**	
01	Client cannot use if allergic to latex	A
02	Each condom can be used only one time	B
03	Some lubricants may be used (male condom— water soluble only; female condom —any lubricant)	C
04	Can be used as backup method if client fears other method will fail	D
05	Dual protection (from pregnancy and against STIs, including HIV)	E
06	None of the above	Y
116	CHECK Q111: IS "H" CIRCLED IN EITHER COLUMN "A" OR "B" OR IN BOTH COLUMNS "A" AND "B"? YES ☐ NO ☐ →	118
117*	**INTRAUTERINE CONTRACEPTIVE DEVICE (IUCD) (COPPER-T)**	
01	Good for up to 5 years or 12 years	A
02	Should return to the clinic 3-6 weeks post insertion or after first menses	B
03	Common side effects that may occur (heavy bleeding for first few months post insertion, spotting or mild abdominal cramps)	C
04	Should return to clinic if side effects continue	D
05	User should regularly check strings after each menstruation	E
06	Method does not protect against STIs, including HIV	F
07	None of the above	Y

NO.	QUESTIONS / OBSERVATIONS	CODES
118	CHECK Q111: IS "I" CIRCLED IN EITHER COLUMN "A" OR "B" OR IN BOTH COLUMNS "A" AND "B"? YES ☐ NO ☐ → 120	
119*	**IMPLANTS (ZEDEL / INDOPLANT)**	
01	Good for 3-5 years	A
02	Changes that may occur with menstruation (irregular bleeding, decreased flow, spotting)	B
03	Initial side effects that may occur (such as nausea, weight gain, breast tenderness)	C
04	Should return to clinic if side effects continue	D
05	Method does not protect against STIs, including HIV	E
06	None of the above	Y
120	CHECK Q111: IS "J" CIRCLED IN EITHER COLUMN "A" OR "B" OR OR IN BOTH COLUMNS "A" AND "B"? YES ☐ NO ☐ → 122	
121	**EMERGENCY CONTRACEPTIVE PILL (ECP)**	
01	Take another dose if vomit within 2 hours of taking a dose	A
02	Return for pregnancy check if period is unusually light or fails to occur within 4 weeks	B
03	First dose to be taken within 72 hours of unprotected sexual contact	C
04	Second dose should be taken 12 hours after first dose	D
05	Not for routine contraception and therefore regimen not to be repeated or taken more than three times in any one month	E
06	Method does not protect against STIs, including HIV	F
07	None of the above	Y
122*	CHECK Q111: IS "L" CIRCLED IN COLUMN "B"? YES ☐ NO ☐ → 124	
123	**PERIODIC ABSTINENCE**	
01	How to identify a woman's fertile period	A
02	No intercourse during woman's fertile period without alternative method (condom)	B
03	Method does not protect against STIs, including HIV	C
04	None of the above	Y
124	CHECK Q111: IS "M" CIRCLED IN EITHER COLUMN "A" OR "B" OR IN BOTH COLUMNS "A" AND "B"? YES ☐ NO ☐ → 126	
125*	**VASECTOMY**	
01	Partner is protected from pregnancy after 3 months or after 30 ejaculations	A
02*	Use of a back-up method for the next 3 months (Condom)	B
03	Procedure intended to be permanent; slight risk of failure	C
04	Warning signs that may occur after surgery (severe pain, tenderness, bleeding)	D
05	Should return to clinic if experience warning signs	E
06	Method does not protect against STIs, including HIV	F
07*	Written Consent was obtained (to be observed)	G
08	None of the above	Y

NO.	QUESTIONS / OBSERVATIONS	CODES
126	CHECK Q111: IS "N" CIRCLED IN EITHER COLUMN "A" OR "B" OR IN BOTH COLUMNS "A" AND "B"? YES ☐ NO ☐ → 128	
127*	**FEMALE STERILIZATION**	
01	Protect from pregnancy immediately	A
02	Procedure intended to be permanent, slight risk of failure	B
03	Warning signs that may occur after surgery (severe pain, light-headedness, fever, bleeding, missed periods)	C
04	Should return to clinic if experience warning sign	D
05	Method does not protect against STIs, including HIV	E
06*	Written consent was obtained (to be observed)	f
07	None of the above	Y
128	CHECK Q111: IS "O" CIRCLED IN COLUMN "B"? YES ☐ NO ☐ → 130	
129	**LACTATIONAL AMENORRHEA (LAM)**	
01	Slight risk of pregnancy during the time shortly before regular menstruation resumes	A
02	Must be exclusively (or near-exclusively) breastfeeding	B
03	Not effective after menstruation begins again	C
04	Infant must be less than 6 months	D
05	Method does not protect against STIs, including HIV	E
06	None of the above	Y

ADDITIONAL PROVIDER ACTIONS

130	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING	
01	Look at client's health card at any time before beginning the consultation, while collecting information or while examining the client	A
02	Wrote on the client's health card	B
03	Used any visual aids for health education or counseling about family planning methods	C
04	Discussed a return visit	D
05	None of the above	Y

CONFIRM WITH PROVIDER

131	CONFIRM THE FOLLOWING WITH THE PROVIDER AT THE END OF THE CONSULTATION. CHECK THE CLIENT CARD OR REGISTER IF NECESSARY.		
01	Has this client had any previous contact with a family planning provider in this facility?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
02	Has this client ever been pregnant?	YES. . . . . 1 NO. . . . . 2 MALE CLIENT. . . . . 3 DON'T KNOW. 8	

NO.	QUESTIONS / OBSERVATIONS	CODES

5. CLINICAL OBSERVATION

201	INDICATE WHICH OF THE FOLLOWING PROCEDURES WAS CONDUCTED DURING THIS VISIT		
01	PELVIC EXAMAMINATION	A	
02*	IUCD INSERTION AND/OR REMOVAL OR IUCD CHECKUP	B	
03	INJECTABLE GIVEN	C	
04	IMPLANT INSERTION AND/OR REMOVAL	D	
05	NONE OF THE ABOVE	Y	→ 301
202	IS THE CLINICAL PROVIDER THE SAME PERSON WHO PROVIDED COUNSELLING?	YES . . . . . 1 NO 2	→ 206

READ TO PROVIDER: Hello, I am representing New ERA. We are conducting a study of health facilities, with the goal of finding ways to improve the delivery of services. I would like to observe the procedure you will conduct with this client. [Ms. ___] has agreed that she has no objection to my presence. Observing all components of the services provided to [Ms. ___] will help us to better understand how health services are provided.

Any information relating to this procedure will be completely confidential. If, at any point, you would prefer I leave, please feel free to tell me.

Do you have any questions for me? Do I have your permission to be present during this procedure?

Interviewer's signature

(Indicates respondent's willingness to participate)

		2	0	1	
DAY		MONTH		YEAR	

203	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ 301
204*	RECORD THE TYPE OF PROVIDER PROVIDING MOST OF THE CLINICAL EXAMINATION.	GENERALIST MEDICAL DOCTOR [MDGP]. . . . . 01 GYNECOLOGIST / OBSTETRICIAN . . . . . 02 ANESTHESIOLOGIST . . . . . 03 PATHOLOGIST . . . . . 04 GENERAL SURGEON . . . . . 05 PEDIATRICIAN . . . . . 06 OTHER SPECIALISTS MEDICAL DOCTORS . . . . . 07 MEDICAL OFFICER (MBBS, BDS) . . . . . 08 ANESTHETIC ASSISTANT. . . . . 09 NURSE (MN, BSC NURSE, BN, PCL) / AUXILLARY NURSE MIDWIFE (ANM) 10 HEALTH ASSISTANT (HA) / AHW / SAHW / PUBLIC HEALTH INSPECTOR 12 OTHER CLINICAL STAFF NOT LISTED ABOVE. . . . . 18 NON-CLINICAL STAFF / NO TECHNICAL QUALIFICATION. 95	
205	RECORD THE SEX OF THE PROVIDER CONDUCTING THE CLINICAL EXAMINATION.	MALE . . . . . 1 FEMALE 2	

NO.	QUESTIONS / OBSERVATIONS	CODES

6. PELVIC EXAMINATION

206	**CHECK Q201:** WAS A PELVIC EXAMINATION CONDUCTED?	YES. . . . . 1 NO. 2	→ 210

BEFORE PROCEDURE

207	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING BEFORE PROCEDURE	
01	Ensured that client had visual privacy	A
02	Ensured that client had auditory privacy	B
03	Explained procedure to client before starting	C
04	Prepared all instruments before starting procedure	D
05	Washed hands with soap and water or disinfected hands before starting procedure	E
06	Put on latex gloves before starting procedure	F
07	NONE OF THE ABOVE	Y

DURING PROCEDURE

208	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING DURING PROCEDURE	
01	Used sterilized or high level disinfected (HLD) instruments	A
02	Asked the client to take slow deep breaths and to relax muscles	B
03	Inspected the external genitalia	C
04	Explained speculum procedure to client (if speculum used)	D
05	Inspected the cervix and vaginal mucosa (using speculum and light)	E
06	Performed a bimanual examination (TWO FINGERS IN VAGINA, OTHER HAND PALPATING ABDOMEN)	F
07	NONE OF THE ABOVE	Y

AFTER PROCEDURE

209	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING AFTER THE PROCEDURE	
01	Removed gloves	A
02	Washed or disinfected hands after removing gloves	B
03	Wiped contaminated surfaces with disinfectant	C
04	Placed reusable instruments in chlorine-based disinfecting solution immediately after the procedure	D
05	None of the above	Y

NO.	QUESTIONS / OBSERVATIONS	CODES

7. IUCD INSERTION AND/OR REMOVAL

210	**CHECK 201:** WAS AN IUCD EITHER INSERTED OR REMOVED?	IUCD INSERTION . . . . . A IUCD REMOVAL . . . . . B IUCD CHECKUP . . . . . C NONE OF THE ABOVE. . . . . Y	→ 215

BEFORE PROCEDURE

211	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING BEFORE PROCEDURE.	
01	Ensured that client had visual privacy	A
02	Ensured that client had auditory privacy	B
03	Explained procedure to client before starting	C
04	**(FOR NEW CLIENT)** Reconfirmed client choice of method	D
05	**(FOR NEW CLIENT)** Confirmed client is not pregnant	E
06	Prepared all instruments before starting procedure	F
07	Washed or disinfected hands before starting procedure	G
08	Put on latex gloves before starting procedure	H
09	Clean cervix and vagina with antiseptic	I
10	None of the above	Y

DURING PROCEDURE

212	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING DURING PROCEDURE.	
01	Performed a bimanual examination (TWO FINGERS IN VAGINA, OTHER HAND PALPATING ABDOMEN)	A
02	Conducted a speculum examination before performing bimanual examination	B
03	Inspected the cervix and vaginal mucosa (USING SPECULUM AND LIGHT)	C
04	Used a tenaculum / Vulsellum	D
05	Sounded the uterus before inserting IUCD	E
06	Explained any of the above procedures	F
07	Used the no-touch technique for IUCD insertion	G
08	Used sterilized or high level disinfected (HLD) instruments	H
09	None of the above	Y

AFTER PROCEDURE

213	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING AFTER PROCEDURE.	
01	Removed gloves	A
02	Washed or disinfected hands after removing gloves	B
03	Asked client to wait and rest for 5 minutes after inserting IUCD	C
04	Wiped contaminated surfaces with disinfectant	D
05	Placed reusable instruments in chlorine-based disinfecting solution immediately after the procedure	E
06	NONE OF THE ABOVE	Y

NO.	QUESTIONS / OBSERVATIONS	CODES

POST PROCEDURE COUNSELLING

214	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING AFTER PROCEDURE.	
01	Client told that IUCD is good for up to 5 or 12 years	A
02	Client instructed to return to the clinic 3 to 6 weeks after insertion or after first menses	B
03	Client instructed to regularly check the strings after each menstruation	C
04	Client told she may experience side effects (e.g., heavy bleeding for first few months, spotting, or mild abdominal cramps)	D
05	Client instructed to return to clinic if side effects persisted	E
06	Client provided with a card stating the date IUCD was inserted and the follow-up date	F
07	**(IF IUCD REMOVED)**: Show the removed IUCD to client	G
08	NONE OF THE ABOVE	Y

NO.	QUESTIONS / OBSERVATIONS	CODES

8. INJECTABLE CONTRACEPTIVES

215	**CHECK Q201:** WAS AN INJECTABLE CONTRACEPTIVE GIVEN?	YES . . . . . 1 NO 2	→ 220

BEFORE PROCEDURE

216	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING BEFORE PROCEDURE.	
01	(With a **new client**) Reconfirmed the client's choice of method	A
02	(With a **new client**) Verified that client was not pregnant	B
03	(**Continuing client**) Checked the client's card to ensure giving injection at correct time	C
04	Ensured visual privacy	D
05	Ensured auditory privacy	E
06	Washed/disinfected hands before giving the injection	F
07	Prepared injection in area with clean table or tray to set items on	G
08	None of the above	Y

DURING PROCEDURE

217	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING DURING PROCEDURE	
01	(**If using disposables**) Used new syringe and needle from a sterile sealed pack	A
02	Opened new packet of syringe and needle	B
03	Removed needle from multiple dose vial each time	C
04	Stirred or mixed the bottle *before* drawing dose (Depo)	D
05	Cleaned and air-dried the injection site *before injection*	E
06	Drew back plunger *before* giving injection	F
07	Allowed dose to self-disperse instead of massaging the site	G
08	None of the above	Y

AFTER PROCEDURE

218*	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING AFTER THE PROCEDURE		
01	Disposed of sharps in puncture-resistant container (not overflowing or pierced)		A
02	Tell client not to massage injection site		B
03	Tell the client when to come back for her next injection		C
04*	Tell the client about side effect		D
05	None of the above		Y
219	INDICATE WHETHER THE NEEDLE AND SYRINGE WERE PROVIDED BY THE FACILITY OR PROVIDED BY THE CLIENT.	PROVIDED BY FACILITY. . . . . 1 PROVIDED BY CLIENT. . . . . 2 DON'T KNOW. 8	

NO.	QUESTIONS / OBSERVATIONS	CODES

9. IMPLANT INSERTION AND/OR REMOVAL

220	CHECK 201: WERE IMPLANTS EITHER INSERTED OR REMOVED?	IMPLANT INSERTION. . . . . A IMPLANT REMOVAL. . . . . B NONE OF THE ABOVE. . . . . Y	→ 301

BEFORE PROCEDURE

221	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING BEFORE PROCEDURE.	
01	(With a **new client**) Reconfirmed the client's choice of method	A
02	(With a **new client**) Verified that client was not pregnant	B
03	Ensured visual privacy	C
04	Ensured auditory privacy	D
05	Explained the procedure to client before starting	E
06	Prepared all instruments before the procedure	F
07	Used sterilized or high-level disinfected instruments	G
08	Washed/disinfected hands *before* the procedure	H
09	Put on sterile gloves and maintain sterility during insertion	I
10	None of the above	Y

DURING PROCEDURE

222	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING DURING PROCEDURE.	
01	Cleaned skin where incision was made with antiseptic	A
02	Used sterile towel to protect area	B
03	Used new or sterilized needle and syringe for local anesthetic	C
04	Allowed time for local anesthetic to take effect prior to making incision	D
05	None of the above	Y

AFTER PROCEDURE

223	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING AFTER PROCEDURE.	
01	Disposed of sharps in puncture-resistant containers	A
02	Wiped contaminated surfaces with disinfectant	B
03	Placed instruments in a chlorine solution immediately after completing the procedure	C
04	Removed gloves	D
05	Washed/disinfected hands *after* removing gloves	E
06	Explained care of incision area and removal of the bandage	F
07	Discussed return visit to remove plaster	G
08	Provided client with card stating date implant was inserted and date when the lifespan of the implant will be completed (3 or 5 years later)	H
09	None of the above	Y

NO.	QUESTIONS / OBSERVATIONS	CODES

POST PROCEDURE COUNSELLING

224	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING.	
01	Client instructed that the implant is good for 3-5 years (# OF YEARS DEPENDS ON TYPE)	A
02	Client told about possible menstrual changes and/or side effects	B
03	Client told about other (NON-MENSTRUAL) side effects such as nausea, weight gain, or breast tenderness	C
04	Client instructed to return to clinic if side effects persisted	D
05	**(IN THE CASE OF REMOVAL):** Client shown each implant stick that was removed and assured that all have been removed	E
06	Provided client with a card stating date that implant was inserted and date when implant should be removed	F
07	None of the above	Y

225	INDICATE WHETHER THE NEEDLE AND SYRINGE WERE PROVIDED BY THE FACILITY OR PROVIDED BY THE CLIENT.	PROVIDED BY FACILITY. . . . . 1 PROVIDED BY CLIENT. . . . . 2 DON'T KNOW. 8	

NO.	QUESTIONS / OBSERVATIONS	CODES

10. CLIENT'S FAMILY PLANNING STATUS

TO BE CONFIRMED WITH PROVIDER AFTER CONSULTATION

	AFTER THE CONSULTATION, ASK THE PROVIDER THE FOLLOWING QUESTIONS		
301	What was the client's family planning status at the beginning of this consultation?	CURRENT USER . . . . . 1 NONUSER, USED IN PAST . . . 2 → 304 NONUSER, NO PAST USE . . . 3 → 304 NOT DETERMINED . . . . . 8 → 304	
302	What was the client's principal reason for the visit?	RESUPPLY/ROUTINE FOLLOW-UP . . . . . 1 DISCUSS PROBLEM WITH METHOD. . . . . 2 DESIRE TO CHANGE METHOD (NO PROBLEM). . . . . 3 DESIRE TO DISCONTINUE FP (NO PROBLEM). . . . . 4 DISCUSS OTHER PROBLEM. . . . 5	
303	What was the outcome of the visit? (FOR CURRENT USER)	CONTINUED WITH CURRENT METHOD . . . . . 1 → 305 SWITCHED METHOD . . . . . 2 → 305 PLANNED METHOD SWITCH, NOT RECEIVED TODAY, CONTINUED USE OF CURRENT METHOD . . . . . 3 → 305 PLANNED METHOD SWITCH, NOT RECEIVED TODAY, DISCONTINUED CURRENT METHOD . . . . . 4 → 305 DECIDED TO STOP USING FAMILY PLANNING . . . . . 5 → 306	
304	What was the outcome of the visit? (IF NOT A CURRENT USER)	ACCEPTED TO START METHOD . . . . . 1 DID NOT DECIDE ON METHOD 2 → 306	
305	Did the client leave the facility with a method? IF NO, RECORD THE REASON THE CLIENT DID NOT RECEIVE METHOD.	YES, LEFT WITH METHOD . . . 1 NO, METHOD NOT IN STOCK . . 2 NO, REQUIRES APPOINTMENT . . . . . 3 NO, DELAY RECEIVING DUE TO HEALTH PROBLEM . . . 4 NO, PREGNANCY STATUS UNCERTAIN . . . . . 5 OTHER. . . . . 6 REFERRED ELSEWHERE. 7	
306	INDICATE WHETHER THE PROVIDER WROTE IN OR ON AN INDIVIDUAL CLIENT'S CARD AFTER THE CONSULTATION.	YES . . . . . 1 NO . . . . . 2 NO INDIVIDUAL CARD USED . . 3 DON'T KNOW 8	

GENERAL OBSERVATION

306A	INDICATE WHETHER ANY ON-TH-JOB TRAINING NURSE OR NURSES PARTICIPATED IN THE PROVISION OF CARE TO THIS CLIENT. THEY MAY PARTICIPATE BY TAKING CERTAIN MEASUREMENTS.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
307*	RECORD THE TIME THE OBSERVATION ENDED. . . . . . USE 24 HOURS FORMAT	☐☐ : ☐☐	
308	**Observer's comments:**		

Nepal Health Facility Survey 2015

FP CLIENT EXIT INTERVIEW

FACILITY IDENTIFICATION

FACILITY NUMBER . . . . . | | | | | |

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM]. . . . . | | |

CLIENT CODE [FROM CLIENT LISTING FORM] . . . . . | | |

INFORMATION ABOUT INTERVIEW

DATE:. . . . .

DAY . . . . . | | |

MONTH . . . . . | | |

YEAR 2015

Name of the interviewer: _____

INTERVIEWER CODE. . . . . | | |

1. Information About Visit - FAMILY PLANNING

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	READ TO CLIENT: Hello, I am_____. As my colleague mentioned, we are representing New ERA. We are conducting a study of health facilities in Nepal in order to improve the services this facility offers and would like to ask you some questions about your experiences here today. Please know that whether you decide to allow this interview or not is completely voluntary and will not affect services you receive during any future visit. You may refuse to answer any question, and you may stop the interview at any time. Information from this interview may be provided to researchers for analyses, but neither your name nor the date of services will be on any shared information, so your identity will remain completely confidential. Do you have any questions for me? Do I have your permission to continue with the interview? _____ Interviewer's signature (Indicates respondent's willingness to participate) DAY | MONTH | YEAR: __ __ | __ __ | 2 0 1 _		
100	May I begin the interview?	CLIENT AGREES . . . . . 1 CLIENT REFUSES 2	→ **END**
101*	RECORD THE TIME THE INTERVIEW STARTED USE 24 HOURS FORMAT	__ __ : __ __	
102	RECORD THE SEX OF THE CLIENT	MALE. . . . . 1 FEMALE. 2	
103	Before coming to this facility today, were you taking any steps or using any methods to prevent a pregnancy?	YES . . . . . 1 NO 2	→ 105
104	Have you used a family planning method or taken any steps to prevent pregnancy at any time during the past 6 months?	YES . . . . . 1 NO 2	→ 112
105*	What method were you (last) using? IF CONDOMS WERE PRESCRIBED FOR USE ALONG WITH ANOTHER METHOD, CIRCLE BOTH METHODS.	COMBINED ORAL PILL (OCP). . . . . A PROGESTIN-ONLY PILL. . . . . B PILL (TYPE UNSPECIFIED). . . . . C PROGESTIN-ONLY INJ. (2- 3-MONTHLY) (DEPO). E MALE CONDOM. . . . . F IUCD (COPPER-T). . . . . H IMPLANT (ZEDEL). . . . . I EMERGENCY CONTRACEPTION (ECP). . . . . J NATURAL METHODS (PERIODIC ABSTINENCE). . . . . L MALE STERILIZATION (VASECTOMY). . . . . M FEMALE STERILIZATION (TUBAL LIGATION). . . . N LACTATIONAL AMENORRHEA. . . . . O OTHER_____ X	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
106	Did a provider ask you today whether you were having (or had had) a problem with the method?	YES, ASKED. . . . . 1 NO, DID NOT ASK 2	
107	Have you been having (did you have) any problems with the method?	YES . . . . . 1 NO 2	→ 110
108	Did you mention the problem to the provider during the consultation?	YES . . . . . 1 NO 2	
109	Did the provider suggest any action(s) you should take to resolve the problem?	YES . . . . . 1 NO 2	
110	What was the outcome of this visit—did you decide to continue (restart) the same method or to switch methods?	CONTINUE WITH OR RESTART SAME METHOD. . . . . 1 SWITCH METHOD. . . . . 2 STOP USING METHOD (DUE TO PROBLEMS). . . . . 3 STOP USING METHOD (ELECTIVE-NO PROBLEMS). . . . 4	→ 201
111	Had you thought about switching methods, and which method to switch to, before you came here today?	YES . . . . . 1 NO 2	→ 113 → 115
112	Had you thought about what family planning method you wanted to use before you came here today?	YES . . . . . 1 NO 2	→ 115
113*	What method was that?	COMBINED ORAL PILL (OCP). . . . . A PROGESTIN-ONLY PILL. . . . . B PILL (TYPE UNSPECIFIED). . . . . C PROGESTIN-ONLY INJ. (2- 3-MONTHLY) (DEPO). E MALE CONDOM. . . . . F IUCD (COPPER-T). . . . . H IMPLANT (ZEDEL). . . . . I EMERGENCY CONTRACEPTION (ECP). . . . . J NATURAL METHODS (PERIODIC ABSTINENCE). . . . . L MALE STERILIZATION (VASECTOMY). . . . . M FEMALE STERILIZATION (TUBAL LIGATION). . . . N LACTATIONAL AMENORRHEA. . . . . O OTHER_____ X	
114	Did the provider talk to you about any of the method(s) you just mentioned?	YES . . . . . 1 NO 2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
115*	What (other) family planning methods did the provider talk with you about? CIRCLE ALL METHODS MENTIONED.	COMBINED ORAL PILL (OCP). . . . . A PROGESTIN-ONLY PILL. . . . . B PILL (TYPE UNSPECIFIED). . . . . C PROGESTIN-ONLY INJ. (2- 3-MONTHLY) (DEPO). E MALE CONDOM. . . . . F IUCD (COPPER-T). . . . . H IMPLANT (ZEDEL). . . . . I EMERGENCY CONTRACEPTION (ECP). . . . . J NATURAL METHODS (PERIODIC ABSTINENCE). . . . . L MALE STERILIZATION (VASECTOMY). . . . . M FEMALE STERILIZATION (TUBAL LIGATION). . . . N LACTATIONAL AMENORRHEA. . . . . O OTHER_____ X	

116*	What family planning method did you either receive or get a prescription or referral for? CIRCLE ALL METHODS THE CLIENT HAS A PRESCRIPTION OR A REFERRAL (PRES), OR RECEIVED IN FACILITY (REC). IF THE CLIENT IS CONTINUING WITH A PRIOR METHOD AND DID NOT RECEIVE ANY METHOD, PRESCRIPTION OR REFERRAL DURING THIS VISIT, CIRCLE "Y" CHECK PACKET OR PRESCRIPTION TO CONFIRM TYPE OF PILL OR INJECTION	PRES / REC COMBINED ORAL PILL (OCP). . . . . A A PROGESTIN-ONLY PILL. . . . . B B PILL (TYPE UNSPECIFIED). . . . . C C PROGESTIN-ONLY INJ. (2- 3-MONTHLY) (DEPO). E E MALE CONDOM. . . . . F F IUCD (COPPER-T). . . . . H H IMPLANT (ZEDEL). . . . . I I EMERGENCY CONTRACEPTION (ECP). . . . . J J NATURAL METHODS (PERIODIC ABSTINENCE). . . . . L L MALE STERILIZATION (VASECTOMY). . . . . M M FEMALE STERILIZATION (TUBAL LIGATION). . . . N N LACTATIONAL AMENORRHEA. . . . . O O OTHER_____ X X CONTINUING WITH METHOD IN Q105. . . . . Y Y NO METHOD. . . . . Z Z → 201 ***[ONLY SKIP TO 201 IF BOTH "Z" ARE CIRCLED IE, NO METHOD EITHER RECEIVED OR PRESCRIBED] OTHERWISE CONTINUE TO Q117***

117	During your consultation today, did the provider	YES	NO	DK
01	Explain how to use the method?	HOW TO USE 1	2	8
02	Talk about possible side effects?	TELL SIDE EFFECTS . . 1	2	8
03	Tell you what to do if you have any problems?	TELL PROBLEMS 1	2	8
04	Tell you when to return for follow-up?	TELL WHEN RETURN . . 1	2	8

NO.	QUESTIONS		CODING CLASSIFICATION	GO TO
118*	MARK BELOW THE METHOD THAT IS CIRCLED IN QUESTION 116. THEN, ASK THE CLIENT THE QUESTION RELATED TO THAT METHOD			
A	PILL (ANY PILL)	How often do you take the pill?	ONCE A DAY. . . . . 1 OTHER. . . . . 2 DON'T KNOW 8	
B	CONDOM (MALE)	How many times can you use one condom?	ONCE . . . . . 1 OTHER. . . . . 2 DON'T KNOW 8	
D	IUCD	What can you do to make sure that your IUCD is in place?	CHECK STRING . . . . . 1 OTHER. . . . . 2 DON'T KNOW 8	
E	PROGESTIN INJECTABLE (e.g. DEPO-PROVERA) 2-3 MONTHS)	How long does the injection provide protection from pregnancy?	2-3 MONTHS . . . . . 1 OTHER. . . . . 2 DON'T KNOW 8	
G	IMPLANT (ZEDEL)	For how long will your implant provide protection against pregnancy?	3-5 YEARS . . . . . 1 OTHER. . . . . 2 DON'T KNOW 8	
H	NATURAL METHOD (PERIODIC ABSTINENCE OR SDM)	How do you recognize the days on which you should not have sexual intercourse?	BODY TEMPERATURE RISES A MUCUS IN VAGINA . . . . . B DAYS 12-16 OF THE MENSTRUAL CYCLE. . . . . C WHITE BEAD' DAYS/DAYS 8-19 OF MENSTRUAL CYCLE. . . . . D OTHER . . . . . X DON'T KNOW . . . . . Z	
I	VASECTOMY [obvs. section asks if provider counsels on slight risk]	How long must you wait before you can rely on your vasectomy to protect against pregnancy?	IMMEDIATE PROTECTION. . . . . 1 1 - 3 MONTHS. . . . . 2 ONLY AFTER 3 MONTHS OR AFTER 30 EJACULATIONS. . . . . 3 DON'T KNOW. 8	
J	TUBAL LIGATION [obvs. section asks if provider counsels on slight risk]	How long must you wait before you can rely on your tubal ligation to protect against pregnancy?	IMMEDIATE PROTECTION. . . . . 1 1 - 3 MONTHS. . . . . 2 ONLY AFTER 3 MONTHS. . . . . 3 DON'T KNOW. 8	
K	LAM	Can you use this method if your menstrual period has returned?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
119	Does your method protect against Sexually Transmitted Infections (STIs), including HIV/AIDS?		YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 201

2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
Now I am going to ask you some questions about the services you received today. I would like to have your honest opinion about the things that we will talk about. This information will help improve services in general.			
201	How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation? TRY TO DETERMINE THE TIME THE CLIENT ARRIVED AT THE FACILITY AND WHEN THE FACILITY OPENS FOR SERVICES. WE ARE INTERESTED IN THE WAITING TIME FROM THE TIME THE FACILITY OFFICIALLY OPENS	MINUTES . . . . . [ ][ ][ ] SAW PROVIDER IMMEDIATELY . . . . . 000 DON'T KNOW 998	

202 Now I am going to ask about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were **major** or **minor** problems for you.

		MAJOR	MINOR	NO PROBLEM	DK
01	Time you waited to see a provider	1	2	3	8
02	Ability to discuss problems or concerns about family planning	1	2	3	8
03	Amount of explanation you received about the problem or treatment	1	2	3	8
04	Privacy from having others see the examination	1	2	3	8
05	Privacy from having others hear your consultation discussion	1	2	3	8
06	Availability of medicines at this facility	1	2	3	8
07	The hours of service at this facility, i.e., when they open and close	1	2	3	8
08	The number of days services are available to you	1	2	3	8
09	The cleanliness of the facility	1	2	3	8
10	How the staff treated you	1	2	3	8
11	Cost for services or treatments	1	2	3	8

204	Were you charged, or did you pay fees for any services your received or were provided today?	YES . . . . . 1 NO 2	→ 206

205	What is the total amount you paid for all services or treatments you received at this facility today?	TOTAL AMOUNT ☐☐☐☐☐☐ DON'T KNOW 999998	
206	Is this the closest health facility to your home?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	→ 208 → 208
207	What was the main reason you did not go to the facility nearest to your home? IF CLIENT MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE PERSONNEL . . .03 NO MEDICINE . . . . . .04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . . 06 WAS REFERRED . . . . . .07 OTHER. . . . . 96 DON'T KNOW 98	
208	In general, which of the following statements best describes your opinion of the services you either received or were provided at this facility today READ ALL STATEMENTS, CIRCLE ONLY ONE 01): I AM **VERY SATISFIED** WITH THE SERVICES I RECEIVED TODAY. . . . . 1 02): I AM **FAIRLY SATISFIED** WITH THE SERVICES I RECEIVED TODAY. . . . . 2 03): I AM **NEITHER SATISFIED NOR DISSATISFIED** (NEUTRAL) WITH THE SERVICES I RECEIVED TODAY. . . . . 3 04): I AM **FAIRLY DISSATISFIED** WITH THE SERVICES I RECEIVED TODAY. . . . . 4 05): I AM **VERY DISSATISFIED** WITH THE SERVICES I RECEIVED IN FACILITY. . . . 5		
209	Will you recommend this health facility to a friend or family member?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

3. Client Personal Characteristics

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
Now I am going to ask you some questions about yourself. I would like to have your honest responses as this information will help to improve services in general.			
302	How old were you at your last birthday?	AGE IN YEARS . . . . . ☐☐ DON'T KNOW. 98	
303	Have you ever attended school?	YES . . . . . 1 NO 2	→ 304C
304A	What is the highest grade you completed? IF COMPLETED LESS THAN ONE GRADE, RECORD "00" *CODES FOR GRADES 00 = NOT PASSED GRADE I 01-09 = GRADE 1 TO 9 PASSED 10 = SLC PASSED 11 = PASSED PROFICIENCY CERTIFICATE 12 = PASSED BACHELOR DEGREE 13 = PASSED MASTER OT HIGHER DEGREE	GRADE . . . . . ☐☐	
304B	CHECK Q304A GRADE 5 OR LOWER ☐ ↓ GRADE 6 OR HIGHER ☐ →		305A
304C	Now I would like you to read this sentence to me. SHOW CARD TO RESPONDENT. IF RESPONDENT CANNOT READ WHOLE SENTENCE, PROBE: Can you read any part of the sentence to me?	YES, CANNOT READ AT ALL 1 ABLE TO READ ONLY PARTS OF SENTENCE . . . . . 2 ABLE TO READ WHOLE SENTENCE. . . . . 3 NO CARD WITH REQUIRED LANGUAGE_____ 4 (SPECIFY LANGUAGE) BLIND/VISUALLY IMPAIRED. . . . 5	
305A*	What isyour caste/ethnicity?	BRAHMIN / CHHETTRI. . . . . 01 TERAI MADHESI OTHER CASTES. . . . . 02 DALIT. . . . . 03 NEWAR. . . . . 04 JANJATI. . . . . 05 MUSLIM. . . . . 06 OTHER CATEGORY. 96	
306*	RECORD THE TIME THE INTERVIEW ENDED USE 24 HOURS FORMAT	☐☐ : ☐☐	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		

Interviewer's comments:

Sample List for SICK CHILD Observation

Date | | | | | **2** | **0** | **1** | |
DAY MONTH YEAR

FACILITY #

TOTAL # OF SICK CHILDREN ON DAY OF VISIT FOR ALL PROVIDERS

USE THIS FORM TO LIST SICK CHILDREN SELECTED FOR OBSERVATION FOR PROVIDER #1

	NAME/INITIALS OF SAMPLED SICK CHILDREN	AGE IN MONTHS
301		
302		
303		
304		
305		
306		
307		
308		
309		
310		
311		
312		
313		
314		
315		
316		
317		
318		
319		
320		
321		
322		
323		
324		
325		

Sample List for SICK CHILD Observation

Date | | | | | **2** | **0** | **1** | | | | | | | |
DAY MONTH YEAR FACILITY #

USE THIS FORM TO LIST SICK CHILDREN SELECTED FOR OBSERVATION FOR PROVIDER #2

	NAME/INITIALS OF SAMPLED SICK CHILDREN	AGE IN MONTHS
326		
327		
328		
329		
330		
331		
332		
333		
334		
335		
336		
337		
338		
339		
340		
341		
342		
343		
344		
345		
346		
347		
348		
349		
350		

Sample List for SICK CHILD Observation

Date | | | | | **2** | **0** | **1** | | | | | | | |

DAY MONTH YEAR FACILITY #

USE THIS FORM TO LIST SICK CHILDREN SELECTED FOR OBSERVATION FOR PROVIDER #3

	NAME/INITIALS OF SAMPLED SICK CHILDREN	FOLLOW-UP
351		
352		
353		
354		
355		
356		
357		
358		
359		
360		
361		
362		
363		
364		
365		
366		
367		
368		
369		
370		
371		
372		
373		
374		
375		

Nepal Health Facility Survey-2015

OBSERVATION OF SICK CHILD CONSULTATION

1. Facility Identification

QTYPE [S] [C] [O]

FACILITY NUMBER. . . . . [ ][ ][ ][ ][ ]

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM] . . . . . [ ][ ]

CLIENT CODE [FROM CLIENT LISTING FORM] . . . . . [ ][ ][ ]

2. Provider Information

Provider category:

GENERALIST MEDICAL DOCTOR [MDGP].	01
GYNECOLOGIST / OBSTETRICIAN	02
ANESTHESIOLOGIST	03
PATHOLOGIST	04
GENERAL SURGEON	05
PEDIATRICIAN	06
OTHER SPECIALISTS MEDICAL DOCTORS	07
MEDICAL OFFICER [MBBS, BDS].	08
ANESTHETIC ASSISTANT.	09
NURSE (MN, BSC NURSE, BN, PCL) / AUXILLARY NURSE MIDWIFE (ANM)	10
HEALTH ASSISTANT (HA) / AHW / SAHW / PUBLIC HEALTH INSPECTOR	12
OTHER CLINICAL STAFF NOT LISTED ABOVE	18
NON-CLINICAL STAFF / NO TECHNICAL QUALIFICATION.	95

PROVIDER CATEGORY [ ][ ]

SEX OF PROVIDER: (1=Male; 2=Female)

SEX OF PROVIDER . . . . . [ ]

3. Information About Observation

Date:. . . . .

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . 2 0 1 [ ]

Name of the observer: _____

OBSERVER CODE . . . . . [ ][ ]

4. OBSERVATION OF SICK CHILD CONSULTATION

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO

BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE CLIENT. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT AN "EXPERT" TO BE CONSULTED DURING THE SESSION.

READ TO PROVIDER: Hello. I am [OBSERVER]. I am representing New ERA.
We are conducting a study of health facilities in Nepal with the goal of finding ways to improve the delivery of services. I would like to observe your consultation with this client in order to understand how services for sick children are provided in this facility.

Information from this observation is confidential. Neither your name nor that of the client will be recorded. The information acquired during this observation may be used by the MOH or other organizations to improve services, or for research on health services; however, neither your name nor the names of your clients will be entered in any database.

Do you have any questions for me? If at any point you feel uncomfortable you can ask me to leave. However, we hope you won't mind our observing your consultation.

Do I have your permission to be present at this consultation?

Interviewer's signature
(Indicates respondent's willingness to participate)

DAY	MONTH	YEAR
		2015

100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**

READ TO CLIENT: Hello, I am_____. I am representing New ERA.
We are conducting a study of health services inNepal. I would like to be present while you are receiving services today in order to understand how sick child services are provided in this facility.

We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. And although information from this observation may be provided to researchers for analyses, neither your name nor the date of service will be provided in any shared data, so your identity and any information about you will remain completely confidential.

Please know that whether you decide to allow me to observe your visit is completely voluntary and that whether you agree to participate or not will not affect the services you receive. If at any point you would prefer I leave please feel free to tell me.

After the consultation, my colleague would like to talk with you about your experience here today. Do you have any questions for me at this time? Do I have your permission to be present at this consultation?

Interviewer's signature
(Indicates respondent's willingness to participate)

101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CARETAKER.	YES . . . . . 1 NO 2	→ **END**
102	RECORD THE TIME THE OBSERVATION STARTED . . . . . USE 24 HOURS FORMAT	☐☐ : ☐☐	
103	IS THIS THE FIRST OBSERVATION FOR THIS PROVIDER FOR THIS SERVICE?	YES . . . . . 1 NO 2	
104	RECORD SEX OF THE CHILD. CONFIRM SEX OF CHILD WITH THE PROVIDER	MALE . . . . . 1 FEMALE 2	

5. PROVIDER INTERACTION WITH CARETAKER AND CHILD

NO.	QUESTIONS / OBSERVATIONS	CODES
FOR EACH OF THE GROUPS THAT FOLLOW, CIRCLE ANY ACTIONS TAKEN BY THE PROVIDER OR THE CLIENT. IF NO ACTION IN THE GROUP IS TAKEN, CIRCLE "Y" FOR EACH GROUP AT THE END OF THE OBSERVATION		

CLIENT HISTORY

105	RECORD WHETHER A PROVIDER ASKED ABOUT OR WHETHER THE CARETAKER MENTIONED THAT THE CHILD HAD ANY OF THE FOLLOWING **MAIN SYMPTOMS**	
01	Fever	A
02	Cough or difficult breathing (e.g., fast breathing or chest in-drawing)	B
03	Diarrhea	C
04	Ear pain or discharge	D
05	None of the above	Y
106	RECORD WHETHER A PROVIDER ASKED ABOUT OR WHETHER THE CARETAKER MENTIONED ANY OF THE FOLLOWING **GENERAL DANGER SIGNS**	
01	Child is unable to drink or breastfeed	A
02	Child vomits everything	B
03	Child has had convulsions with this illness	C
04	None of the above	Y
107	RECORD WHETHER A PROVIDER CHECKED FOR **SUSPECTED SYMPTOMATIC HIV** INFECTION BY **ASKING FOR ANY OF THE FOLLOWING:**	
01	Mother's HIV status	A
02	TB infection in any parent in the last 5 years	B
03	Two or more episodes of diarrhea in child each lasting 14 days or more	C
04	None of the above	Y

PHYSICAL EXAMINATION

108	RECORD WHETHER A PROVIDER PERFORMED ANY OF THE FOLLOWING **PHYSICAL EXAMINATIONS ON THE SICK CHILD**	
01	Took child’s temperature by thermometer	A
02	Felt the child for fever or body hotness	B
03	Counted respiration (breaths) for 60 seconds	C
04	Auscultated child (listen to chest with stethoscope) or count pulse	D
05	Checked skin turgor for dehydration (e.g., pinch abdominal skin)	E
06	Checked for pallor by looking at palms	F
07	Checked for pallor by looking at conjunctiva	G
08	Looked into child's mouth	H
09	Checked for neck stiffness	I
10	Looked in child’s ear	J
11	Felt behind child’s ear	K
12	Undressed child to examine (up to shoulders/down to ankles)	L
13	Pressed both feet to check for edema	M
14	Weighed the child	N
15	Plotted weight on growth chart (child health card-HMIS 2.1, growth monitoring chart)	O
16	Checked for enlarged lymph nodes in 2 or more of the following sites: neck, axillae, groin	P
17	None of the above	Y

NO.	QUESTIONS / OBSERVATIONS	CODES

OTHER ASSESSMENTS

109*	RECORD WHETHER A PROVIDER ASKED ABOUT OR PERFORMED OTHER ASSESSMENTS OF THE CHILD'S HEALTH **BY DOING ANY OF THE FOLLOWING:**	
01	Offered the child something to drink or asked the mother to put the child to the breast MARK AS YES IF YOU OBSERVE CHILD DRINKS OR BREASTFEEDS DURING VISIT	A
02	Asked about normal ***feeding*** habits or practices when the child is not ill	B
03	Asked about normal ***breastfeeding*** habits or practices when the child is not ill	C
04	Asked about feeding or breastfeeding habits or practices for child during this illness	D
05	Mentioned the child's weight or growth to the caretaker, or discussed growth chart	E
07	Asked if child received Vitamin A within past 6 months	G
08*	Looked at the child's health card either before beginning the consultation, or while collecting information from the caretaker, or while examining the child (HMIS 2.1) THIS ITEM MAY BE EITHER THE VACCINATION CARD OR OTHER HEALTH CARD	H
09	Wrote on the child's health card	I
10	Asked if child received any de-worming medication in last 6 months	J
11*	Asked about the child vaccination status	K
12	None of the above	Y

COUNSELING OF CARETAKER

110	RECORD WHETHER A PROVIDER DID ANY OF THE FOLLOWING	
01	Provided general information about feeding or breastfeeding the child even when not sick	A
02	Told the caretaker to give extra fluids to the child during this illness	B
03	Told the caretaker to continue feeding the child during this illness	C
04	Told the caretaker what illness(es) the child has	D
05	Described signs and/or symptoms in the child for which to immediately bring child back	E
06	Used a visual aid to educate caretaker	F
07	None of the above	Y

ADDITIONAL COUNSELING

111	RECORD WHETHER A PROVIDER DID ANY OF THE FOLLOWING THIS REFERS ONLY TO MEDICINES THAT THE CARETAKER WILL GIVE TO THE SICK CHILD AT HOME AND DOES NOT INCLUDE STAT DOSES OR ONE TIME MEDS GIVEN TO THE CHILD DURING THE VISIT (E.G., ORS OR PAIN MEDICINE) FOR URGENT TREATMENT OF SYPMTOMS.	
01	Prescribed or provided oral medications during or after consultation	A
02	Explained how to administer oral treatment(s)	B
03	Asked the caretaker to repeat the instructions for giving medications at home	C
04	Gave the first dose of the oral treatment	D
05	Discuss follow-up visit for the sick child	E
06	None of the above	Y

NO.	QUESTIONS / OBSERVATIONS	CODES

REFERRALS AND ADMISSIONS

112	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING		
01	RECOMMEND THAT CHILD BE HOSPITALIZED URGENTLY (I.E., ADMITTED TO THE HOSPITAL OR REFERRED TO ANOTHER HOSPITAL)		A
02	REFERRED CHILD TO ANOTHER PROVIDER WITHIN FACILITY FOR OTHER CARE		B
03	REFERRED CHILD FOR A LABORATORY TEST WITHIN OR OUTSIDE FACILITY		C
04	EXPLAINED THE REASON FOR (ANY) REFERRAL		D
05	GAVE REFERRAL SLIP TO CARETAKER		E
06	EXPLAINED WHERE (OR TO WHOM) TO GO		F
07	PROVIDER EXPLAINED WHEN TO GO FOR REFERRAL		G
08	NONE OF THE ABOVE		Y
113	WHAT WAS THE OUTCOME OF THIS CONSULTATION? [THIS IS THE POINT WHEN THE OBSERVATION IS CONCLUDED]	TREATED AND SENT HOME. . . . . 1 CHILD REFERRED TO OTHER PROVIDER, SAME FACILITY. . . . . 2 CHILD ADMITTED, SAME FACILITY. . . . . 3 CHILD SENT TO LAB. . . . . 4 CHILD REFERRED TO OTHER FACILITY. 5	

NO.	QUESTIONS / OBSERVATIONS	CODES

6. DIAGNOSIS

ASK THE PROVIDER TO TELL YOU THE DIAGNOSIS FOR THE SICK CHILD. IF A DIAGNOSIS OF DEHYDRATION WAS MADE, ASK IF IT WAS SEVERE, MILD, OR MODERATE AND INDICATE ACCORDINGLY. FOR ANY OTHER DIAGNOSIS, SIMPLY CIRCLE THE DIAGNOSIS MADE.

	DIAGNOSIS (OR MAIN SYMPTOM, IF NO DIAGNOSIS)	
201	**DEHYDRATION**	
	SEVERE DEHYDRATION. . . . . 1 MODERATE DEHYDRATION. . . . . 2 MILD DEHYDRATION. . . . . 3 NONE OF THE ABOVE / NO DEHYDRATION. 8	
202	**RESPIRATORY SYSTEM**	
	PNEUMONIA . . . . . A BRONCHIAL SPASM / ASTHMA. . . . . B UPPER RESPIRATORY TRACT INFECTION (URI)/ACUTE RESPIRATORY ILLNESS (ARI). . . . . C RESPIRATORY ILLNESS, DIAGNOSIS UNCERTAIN. . . . . D COUGH, DIAGNOSIS UNCERTAIN. . . . . E NONE OF THE ABOVE. . . . . Y	
203	**DIGESTIVE SYSTEM / INTESTINAL**	
	ACUTE WATERY DIARRHEA. . . . . A DYSENTERY. . . . . B AMEBIASIS. . . . . C PERSISTENT DIARRHEA. . . . . D OTHER DIGESTIVE / INTESTINAL (SPECIFY)_____ . . . . . X NONE OF THE ABOVE. . . . . Y	
204	**MALARIA**	
	MALARIA (CLINICAL DIAGNOSIS). . . . . 1 MALARIA (BLOOD SMEAR) . . . . . 2 MALARIA (RAPID DIAGNOSTIC TEST) . . . . . 3 NONE OF THE ABOVE. 8	
205	**FEVER/MEASLES**	
	FEVER OF UNKNOWN ORIGIN. . . . . 1 MEASLES WITH NO COMPLICATIONS. . . . . 2 MEASLES WITH COMPLICATIONS (E.G., MOUTH/EYE OR SEVERE). . . . . 3 TYPHOID FEVER. . . . . 4 URINARY TRACT INFECTION. . . . . 5 SEPTICEMIA. . . . . 6 MENINGITIS. . . . . 7 NONE OF THE ABOVE. 8	
206	**EAR**	
	MASTOIDITIS. . . . . A ACUTE EAR INFECTION. . . . . B CHRONIC EAR INFECTION. . . . . C OTHER EAR INFECTION. . . . . X NONE OF THE ABOVE. . . . . Y	
207	**THROAT**	
	SORE THROAT / PHARYNGITIS. . . . . 1 OTHER THROAT DIAGNOSIS (SPECIFY)_____. . . . . 2 NONE OF THE ABOVE. 8	

NO.	QUESTIONS / OBSERVATIONS	CODES
208	**OTHER DIAGNOSIS**	
	ABSESS. . . . . A BACTERIAL CONJUCTIVITIS. . . . . B SKIN CONDITION. . . . . C OTHER DIAGNOSIS (SPECIFY)_____ X NO OTHER DIAGNOSIS. . . . . Y	

NO.	QUESTIONS / OBSERVATIONS	CODES

7. TREATMENT

ASK ABOUT THE TREATMENT THAT WAS EITHER PRESCRIBED OR PROVIDED. PROMPT IF NECESSARY.

209	Did you prescribe any treatment today for this child? IF YES, CIRCLE ALL TREATMENTS THAT WERE PRESCRIBED OR PROVIDED TO CHILD IN THE FOLLOWING QUESTIONS	YES. . . . . 1 NO. 2	→ 215
210	**GENERAL TREATMENT**		
01	BENZYL PENICILLIN INJECTION		A
02	OTHER ANTIBIOTIC INJECTION		B
03	OTHER INJECTION		C
04	CO-TRIMOXAZOLE TABLETS		D
05	CO-TRIMOXAZOLE SYRUP		E
06	AMOXICILLIN CAPSULES		F
07	AMOXICILLIN SYRUP		G
08	OTHER ANTIBIOTIC TABLET/SYRUP		H
09	PARACETAMOL		I
10	OTHER FEVER REDUCING MEDICINE		J
11	ZINC		K
12	VITAMINS (OTHER THAN VITAMIN A)		L
13	COUGH SYRUPS/OTHER MEDICATION		M
14*	ANTIHISTAMINE		N
15	NONE OF THE ABOVE		Y
211	**RESPIRATORY**		
01	NEBULISER OR INHALER		A
02	INJECTABLE BRONCHODILATOR/ADRENERGIC		B
03	ORAL BRONCHODILATOR		C
04	DRY EAR BY WICKING		D
05	NONE OF THE ABOVE		Y
212*	**MALARIA**		
01	INJECTABLE QUININE		A
02	INJECTABLE ARTEMETHER / ARTESUNATE		B
03	ORAL ACT/AL (E.G., COARTEM)		E
04	ORAL ARTEMETER / ARTESUNATE		F
05	ORAL QUININE		I
06	OTHER ORAL ANTIMALARIAL		J
07*	CHLOROQUINE		K
08*	PRIMAQUINE		L
09	NONE OF THE ABOVE		Y

NO.	QUESTIONS / OBSERVATIONS	CODES
213	**DEHYDRATION**	
01	HOME ORT (PLAN A)	A
02	INITIAL ORT IN FACILITY (4 HOURS - PLAN B)	B
03	INTRAVENOUS FLUIDS (PLAN C)	C
04	NONE OF THE ABOVE	Y
214	**OTHER TREATMENT & ADVICE**	
01	VITAMIN A (MAY ALSO BE FOR IMMUNIZATION)	A
02	FEEDING SOLID FOODS	B
03	FEEDING EXTRA LIQUIDS	C
04	FEEDING BREAST MILK	D
05	PRESCRIBED/GAVE DEWORMING TABLETS	E
06	ANY OTHER TREATMENT_____	X
07	NONE OF THE ABOVE	Y

CONFIRM WITH PROVIDER

215	Is this [NAME'S] first visit to this facility for this illness, or is this a follow-up visit?	FIRST VISIT . . . . . 1 FOLLOW-UP . . . . . 2 DON'T KNOW. 8	

GENERAL OBSERVATION

216A	INDICATE WHETHER ANY ON-TH-JOB TRAINING NURSE OR NURSES PARTICIPATED IN THE PROVISION OF CARE TO THIS CHILD. THEY MAY PARTICIPATE BY TAKING CERTAIN MEASUREMENTS OR EXAMINING THE CHILD.	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
217*	RECORD THE TIME THE OBSERVATION ENDED. . . . . : : USE 24 HOURS FORMAT		

Observer's comments:

Nepal Health Facility Survey-2015

SICK CHILD CARETAKER EXIT INTERVIEW

FACILITY IDENTIFICATION

FACILITY NUMBER . . . . . | | | | | |

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM]. . . . . | | |

CLIENT CODE [FROM CLIENT LISTING FORM]. . . . . | | |

INFORMATION ABOUT INTERVIEW

DATE:. . . . . .

DAY . . . . . | | |

MONTH . . . . . | | |

YEAR 2015

Name of the interviewer: _____

INTERVIEWER CODE. . . . . | | |

1. Information About Visit - CARETAKER OF SICK CHILD

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	READ TO CLIENT: Hello, I am_____. As my colleague mentioned, we are representing New ERA. We are conducting a study of health facilities in Nepal. in order to improve the services this facility offers and would like to ask you some questions about your experiences here today. Please know that whether you decide to allow this interview or not is completely voluntary and will not affect services you receive during any future visit. You may refuse to answer any question, and you may stop the interview at any time. Information from this interview may be provided to researchers for analyses, but neither your name nor the date of services will be on any shared information, so your identity will remain completely confidential. Do you have any questions for me? Do I have your permission to continue with the interview? Interviewer's signature (Indicates respondent's willingness to participate)	DAY | MONTH | YEAR: 2 0 1	
100	May I begin the interview?	CLIENT AGREES . . . . . 1 CLIENT REFUSES 2	→ **END**
101*	RECORD THE TIME THE INTERVIEW STARTED USE 24 HOURS FORMAT	[ ][ ] : [ ][ ]	
102	What is the name of the sick child?	NAME _____	

CLIENT AGE

103	What month and year was [NAME] born?	MONTH . . . . . [ ][ ] DON'T KNOW MONTH . . . . . 98 YEAR . . . . . [ ][ ][ ][ ] DON'T KNOW YEAR 9998	
104	How old is [NAME] in completed months?	AGE IN MONTHS . . . . . [ ][ ] DON'T KNOW. 9 8	

SIGNS AND SYMPTOMS OF CURRENT ILLNESS

105	Has [NAME] had fever with this illness, or any time in the past two days?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
106	Has [NAME] had a convulsion with this illness?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
107*	Does [NAME] have cough or difficulty breathing or faster breathing / in-drawing intercostal muscle with this illness?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
108	Can [NAME] drink, eat or breastfeed at present?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
109	Does [NAME] vomit everything when he/she eats or breastfeeds during this illness?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	

110	Has [HE/SHE] had watery and frequent stools with this illness or any time in the past two days?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
111	Has [HE/SHE] been excessively sleepy during this illness?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
112*	For what other reason(s) did you bring [NAME] to this health facility today? CIRCLE ALL ITEMS THE RESPONDENT MENTIONS PROBE: Anything else?	EAR PROBLEMS. . . . . A SKIN SORE/PROBLEMS. . . . . B INJURY. . . . . C EYE PROBLEM. . . . . D WEIGHT LOSS. . . . . E OTHER _____ X (SPECIFY) NO OTHER REASON . . . . . Y	
113	Has [NAME] been brought to this facility before for this same illness? IF YES, ASK: How long ago was that?	WITHIN THE PAST WEEK. . . . . 1 WITHIN THE PAST 2-4 WEEKS. . . . 2 MORE THAN 4 WEEKS AGO. . . . . 3 NO. . . . . 4 DON'T KNOW. 8	
114	How many days ago did the illness for which you brought [NAME] here begin? IF LESS THAN 1 DAY, ENTER 00	DAYS AGO. . . . . [ ][ ] DON'T KNOW. 98	

INFORMATION PROVIDED TO CARETAKER

115	Did the provider tell you what illness [NAME] has?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
116*	What would you do if [NAME] does not get completely better or becomes worse?	RETURN TO FACILITY. . . . . 1 GO TO OTHER FACILITY. . . . . 2 GO TO OTHER HEALTH WORKER OR /PHARMACY. . . . . 3 GO TO TRADITIONAL HEALER. . . . 4 NOTHING, JUST WAIT. . . . . 5 OTHER _____ 6 (SPECIFY) DON'T KNOW. 8	
117	Did the provider tell you about any signs or symptoms you may see for which you must immediately bring the child back? IF YES, ASK: Can you tell me what these are? IF NECESSARY, PROBE: Were there any serious symptoms or danger signs for which you were told to bring [NAME] back immediately?	FEVER . . . . . A BREATHING PROBLEMS . . . . . B BECOMES SICKER . . . . . C BLOOD IN STOOL . . . . . D VOMITING . . . . . E POOR/NOT EATING . . . . . F POOR/NOT DRINKING . . . . . G CONVULSION . . . . . H OTHER _____ X (SPECIFY) NO, NONE . . . . . Y DON'T KNOW . . . . . Z	

118	Did the provider tell you anything about bringing [NAME] back to the health facility for follow-up or non-emergency reasons? IF YES: Why were you to return?	MORE MEDICINES . . . . . A IF SYMPTOMS INCREASE OR BECOME WORSE . . . . . B FOLLOW-UP APPOINTMENT. . . . . C VIT. A SUPPLEMENTATION. . . . . D LAB TEST RESULTS. . . . . E CHILD ADMITTED. . . . . F ROUTINE IMMUNISATION . . . . . G OTHER _____ X (SPECIFY) NO. . . . . Y DON'T KNOW . . . . . Z	

TREATMENT AND CARETAKER COMFORT LEVEL

119	Did the provider give or prescribe any medicines for [NAME] to take at home?	YES, GAVE MEDS. . . . . 1 YES, GAVE PRESCRIPTION. . . . . 2 GAVE MEDS AND PRESCRIPTION. . . . . 3 NO 4	→ 124
120	ASK TO SEE ALL MEDICATIONS THAT THE CARETAKER RECEIVED AND ANY PRESCRIPTIONS THAT HAVE NOT YET BEEN FILLED. CIRCLE THE RESPONSE DESCRIBING THE MEDICATIONS AND PRESCRIPTIONS YOU SEE.	HAS ALL MEDS. . . . . 1 HAS SOME MEDS, SOME UNFILLED PRESCRIPTIONS. . . . . 2 NO MEDICATIONS SEEN, HAS PRESCRIPTIONS ONLY. 3	
121	Did a provider at the facility explain to you how to give these medicines to [NAME] at home? IF “2” OR “8” SUGGEST TO CLIENT TO GO BACK TO PROVIDER AT THE END OF THE INTERVIEW	YES. . . . . 1 NO. . . . . 2 DON’T KNOW. 8	
122	Do you feel comfortable or confident that you know how much of each medication to give [NAME] each day and for how many days to give it? IF “2” OR “8” SUGGEST TO CLIENT TO GO BACK TO PROVIDER AT THE END OF THE INTERVIEW	YES. . . . . 1 NO. . . . . 2 DON’T KNOW. 8	
123	Has [NAME] been given a dose of any of these medications here at the facility already?	YES. . . . . 1 NO. . . . . 2 DON’T KNOW. 8	
124	Did [NAME] receive an injection for treating the sickness here at the facility today? IF NO, CHECK PRESCRIPTIONS AND RECORD IF THERE IS A PRESCRIPTION FOR AN INJECTION.	YES, RECEIVED INJECTION. . . . . 1 YES, RECEIVED PRESCRIPTION FOR INJECTION. . . . . 2 NO . . . . . 3 DON’T KNOW 8	
125	Did anyone at the health facility weigh [NAME] today?	YES . . . . . 1 NO 2	
126	Did anyone talk to you today about [NAME]’s weight and how [NAME] is growing?	YES . . . . . 1 NO 2	
127	Did any provider **ask** you today about the types of foods and amounts that you normally feed [NAME] when [NAME] is not sick? i.e. general nutrition care	YES . . . . . 1 NO . . . . . 2 CANNOT REMEMBER 8	
127A	Did any provider **tell** you today about the types of foods and amounts that you normally feed [NAME] when [NAME] is not sick? i.e. general nutrition care	YES . . . . . 1 NO . . . . . 2 CANNOT REMEMBER 8	→ 128
127B	What specifically were you told about nutrition care/food to feed [NAME] when [NAME] is not sick?	VARIETIES OF NUTRITIOUS FOOD ITEMS NEED TO FEED. . . . . A TEXTURE OF FOOD. . . . . B FREQUENCY OF FEEDING. . . . . C HYGIENE DURING FEEDING. . . . . D AMOUNT OF FEEDING. . . . . E OTHER _____ X (SPECIFY) NO. . . . . Y DON’T KNOW . . . . . Z	

128	What did the provider tell you about feeding solid foods to [NAME] during this illness?	GIVE LESS THAN USUAL . . . . . 1 GIVE SAME AS USUAL . . . . . 2 GIVE MORE THAN USUAL . . . . 3 GIVE NOTHING/DON'T FEED . . 4 DIDN'T DISCUSS . . . . . 6 NOT CERTAIN / CAN'T REMEMBER 8	
129	What did the provider tell you about giving fluids (or breast milk, if the child is breastfed) to [NAME] during this illness?	GIVE LESS THAN USUAL . . . . . 1 GIVE SAME AS USUAL . . . . . 2 GIVE MORE THAN USUAL . . . . 3 GIVE NOTHING/DON'T FEED . . 4 DIDN'T DISCUSS . . . . . 6 DON'T KNOW/ CAN'T REMEMBER 8	
130	Was [NAME] given a vaccination today? IF YES, ASK TO SEE THE HEALTH CARD OR BOOKLET TO VERIFY.	YES, OBSERVED. . . . . 1 REPORTED, NOT SEEN. . . . . 2 NO. . . . . 3 DON'T KNOW. 8	

REFERRAL

131	Did the provider instruct you to take [NAME] to see another provider or to a laboratory in this facility for a finger or heel stick for blood to be taken for a test?	YES. . . . . 1 NO. 2	→ 134
132	Did you take [NAME] to the provider or laboratory for the finger or heel stick?	YES. . . . . 1 NO. 2	→ 134
133	Were you told the result of the test that was done?	YES. . . . . 1 NO. 2	
134	Did the provider instruct you to take [NAME] to see a provider in another facility, or for a laboratory test outside of this facility, for further care for [NAME]?	YES. . . . . 1 NO. 2	→ 136
135	Regarding this referral, please tell me:	YES NO DK	
01	Were you given any paper or record to take with you for the referral?	1 2 8	
02	Were you told ***where*** to go for the referral?	1 2 8	
03	Were you told ***who*** to see for the referral?	1 2 8	
04	Were you told ***why*** you are to go for the referral?	1 2 8	
05	Do you intend to go to this (these) referral(s)?	1 2 8	
136	Did you take [NAME] to see another health provider or traditional healer before coming here? IF YES, ASK: Whom did you see and where? CIRCLE ALL THAT APPLY	YES, OTHER PROVIDER THIS FACILITY. . . . . A YES, OTHER PROVIDER DIFFERENT FACILITY. . . B YES, TRADITIONAL HEALER. . . . . C YES, OTHER [e.g. UNANI, AYURVEDA, HOMEOPATHY]. . . . . D SAW NO ONE . . . . . Y	

UNDERWEIGHT

136A	Did the provider tell you that [NAME] is underweight/malnourished?	YES. . . . . 1 NO. 2	→ 201
136B	Did the provider instruct you to take [NAME] to see a provider in another facility and told you where to go (referral) for further care for [NAME]?	YES. . . . . 1 NO. 2	

2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
Now I am going to ask you some questions about the services you received today. I would like to have your honest opinion about the things that we will talk about. This information will help improve services in general.			
201	How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation? TRY TO DETERMINE THE TIME THE CLIENT ARRIVED AT THE FACILITY AND WHEN THE FACILITY OPENS FOR SERVICES. WE ARE INTERESTED IN THE WAITING TIME FROM THE TIME THE FACILITY OFFICIALLY OPENS	MINUTES . . . . . [ ][ ][ ] SAW PROVIDER IMMEDIATELY . . . . . 000 DON'T KNOW 998	

202 Now I am going to ask about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were **major** or **minor** problems for you.

		MAJOR	MINOR	NO PROB-LEM	DK
01	Time you waited to see a provider	1	2	3	8
02	Ability to discuss problems or concerns about [CHILD'S] illness	1	2	3	8
03	Amount of explanation you received about the problem or treatment	1	2	3	8
04	Privacy from having others see the examination	1	2	3	8
05	Privacy from having others hear your consultation discussion	1	2	3	8
06	Availability of medicines at this facility	1	2	3	8
07	The hours of service at this facility, i.e., when they open and close	1	2	3	8
08	The number of days services are available to you	1	2	3	8
09	The cleanliness of the facility	1	2	3	8
10	How the staff treated you	1	2	3	8
11	Cost for services or treatments	1	2	3	8

204	Were you charged, or did you pay fees for any services your received or were provided today?	YES . . . . . 1 NO 2	→ 206

205	What is the total amount you paid for all services or treatments you received at this facility today?	TOTAL AMOUNT ☐☐☐☐☐☐ DON'T KNOW 999998	
206	Is this the closest health facility to your home?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	→ 208 → 208
207	What was the main reason you did not go to the facility nearest to your home? IF CLIENT MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE PERSONNEL . . .03 NO MEDICINE . . . . . .04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . . 06 WAS REFERRED . . . . . .07 OTHER. . . . . 96 DON'T KNOW 98	
208	In general, which of the following statements best describes your opinion of the services you either received or were provided at this facility today READ ALL STATEMENTS, CIRCLE ONLY ONE 01): I AM **VERY SATISFIED** WITH THE SERVICES I RECEIVED TODAY. . . . . 1 02): I AM **FAIRLY SATISFIED** WITH THE SERVICES I RECEIVED TODAY. . . . . 2 03): I AM **NEITHER SATISFIED NOR DISSATISFIED** (NEUTRAL) WITH THE SERVICES I RECEIVED TODAY. . . . . 3 04): I AM **FAIRLY DISSATISFIED** WITH THE SERVICES I RECEIVED TODAY. . . . . 4 05): I AM **VERY DISSATISFIED** WITH THE SERVICES I RECEIVED IN FACILITY. . . . 5		
209	Will you recommend this health facility to a friend or family member?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	

3. Client Personal Characteristics

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
Now I am going to ask you some questions about yourself. I would like to have your honest responses as this information will help to improve services in general.			
301	What is your relationship to [SICK CHILD]?	MOTHER . . . . . 1 FATHER . . . . . 2 SIBLING . . . . . 3 AUNT OR UNCLE . . . . . 4 GRAND MOM/GRAND DAD. . . . . 5 OTHER _____ 6 (SPECIFY)	
302	How old were you at your last birthday?	AGE IN YEARS . . . . . ☐☐ DON'T KNOW. 98	
303	Have you ever attended school?	YES . . . . . 1 NO 2	→ 304C
304A	What is the highest grade you completed? IF COMPLETED LESS THAN ONE GRADE, RECORD "00" *CODES FOR GRADES 00 = NOT PASSED GRADE I 01-09 = GRADE 1 TO 9 PASSED 10 = SLC PASSED 11 = PASSED PROFICIENCY CERTIFICATE 12 = PASSED BACHELOR DEGREE 13 = PASSED MASTER OT HIGHER DEGREE	GRADE . . . . . ☐☐	
304B	CHECK Q304A GRADE 5 OR LOWER ☐ ↓ GRADE 6 OR HIGHER ☐ →		305A
304C	Now I would like you to read this sentence to me. SHOW CARD TO RESPONDENT. IF RESPONDENT CANNOT READ WHOLE SENTENCE, PROBE: Can you read any part of the sentence to me?	YES, CANNOT READ AT ALL 1 ABLE TO READ ONLY PARTS OF SENTENCE . . . . 2 ABLE TO READ WHOLE SENTENCE. . . . . 3 NO CARD WITH REQUIRED LANGUAGE _____ 4 (SPECIFY LANGUAGE) BLIND/VISUALLY IMPAIRED. . . . 5	
305A*	What is your caste/ethnicity?	BRAHMIN / CHHETTRI. . . . . 01 TERAI MADHESI OTHER CASTES. . . . . 02 DALIT. . . . . 03 NEWAR. . . . . 04 JANJATI. . . . . 05 MUSLIM. . . . . 06 OTHER CATEGORY. 96	
306	RECORD THE TIME THE INTERVIEW ENDED USE 24 HOURS FORMAT	☐☐ : ☐☐	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		

Interviewer's comments:

Sample List for POST PARTUM WOMEN

Date | | | | | **2** | **0** | **1** | |
DAY MONTH YEAR

FACILITY #

TOTAL # OF POST PARTUM WOMEN ON DAY OF VISIT FOR ALL PROVIDERS | | |

USE THIS FORM TO LIST POST PARTUM WOMEN SELECTED FOR EXIT FOR ALL PROVIDERS

	NAME/INITIALS OF SAMPLED POST PARTUM WOMEN	
401		
402		
403		
404		
405		
406		
407		
408		
409		
410		
411		
412		
413		
414		
415		
416		
417		
418		
419		
420		
421		
422		
423		
424		
425		

Nepal Health Facility Survey – 2015

Exit Interview Questionnaire for Postpartum Women

1. FACILITY NUMBER.....	☐☐☐☐☐
2. PROVIDER SERIAL NUMBER (FROM STAFF LISTING FORM).....	9 9
3. CLIENT CODE (FROM CLIENT LISTING FORM	☐☐☐
4. FACILITY HAS IMPLEMENTED "AAMA PROGRAM" YES .....1 NO 2	

INFORMATION ABOUT INTERVIEW

Date_____	Day .....☐☐
Name of interviewer:_____	Month .....☐☐
	Year.....2 0 1 5
	Interviewer code .....☐☐☐

READ TO CLIENT: Hello, I am_____, we are representing New ERA which is located in Kathmandu. Currently, we are conducting health facility survey all over Nepal for MoHP, Nepal. This survey aims to collect health facility related information in order to improve the services, this facility is providing. I would like to ask you some questions about your experiences here today. Please know that whether you decide to allow this interview or not is completely voluntary and will not affect services you receive during any future visit. You may refuse to answer any question, and you may stop the interview at any time.

Information from this interview will be used by MoHP for planning service improvement or for conducting further studies of health services and may be provided to researchers for analyses, but neither your name nor the date of services will be on any shared information, so your identity will remain completely confidential.

Do you have any questions for me? Do I have your permission to continue with the interview?

☐☐ ☐☐ 2 0 1 5

_____
Interviewer's signature
(Indicates respondent's willingness to participate)

Day Month Year

100. BACKGROUND

S.N.	Question/Information	Coding Categories	Skip
100	May I begin the interview now?	Agrees.....1 Client refuses.....2 → End	
101	RECORD THE TIME OF INTERVIEW STARTED **USE 24 Hrs FORMAT**	☐☐ : ☐☐	
102	RECORD ADMISSION DATE FROM THE DISCHARGE SLIP	☐☐ Day ☐☐ Month ☐☐☐☐ Year	
102A	RECORD ADMISSION TIME FROM THE DISCHARGE SLIP	Time ☐☐ : ☐☐	
103	What is your caste/ethnicity ?	Brahmin/Chhettri..... 1 Terai Madhesi other castes ..... 2 Dalit..... 3 Newar..... 4 Janajati..... 5 Muslim..... 6 Others 96	
104	How old are you?	Age in years ..... ☐☐ Don't know.....98	
105	Where do you live?	District_____.....☐☐ VDC/Municipality_____..... ☐☐☐ (Name) Ward Number.....☐☐ Tole name (Specify)_____	
106	Have you ever been to school?	Yes.....1 No .....2 → 107C	
107A	What is the highest level of school you attended ? **(If Completed Less Than One Grade, Record '00')**	Highest grade completed* ..... ☐☐	

Codes for Grades

00 = Not passed grade I	11 = Passed proficiency certificate
01-09 = Grade 1 to 9 passed	12 = Passed Bachelor degree
10 = SLC passed	13 = Passed Master or higher degree

107B	**Check Q. 107A** **Grade 5 or Lower** ☐ ↓	Grade 6 or higher ☐ → 201	
107C	Now I would like you to read this sentence to me. SHOW CARD TO RESPONDENT. IF RESPONDENT CANNOT READ WHOLE SENTENCE, PROBE: Can you read any part of the sentence to me?	Cannot read at all.....1 Able to read only parts of sentence .....2 Able to read whole sentence.....3 No card with required language .....4 Blind/visually impaired 5	

200. ACCESSING CARE AND DECISION MAKING

S.N.	Question/Information	Coding Categories	Skip
201	Who made the decision for you to come and deliver in this health facility?	Self.....A Husband .....B Parents .....C Parents-in-law.....D Son/daughter .....E Brother/sister .....F Brother-/sister-in-law..... G Other relative .....H FCHV ..... I Outreach health worker .....J Was referred from other facility .....K Others (Specify) _____.....X	→ 203 → 203
202	**Ask if Q201=K** Who made the decision for you to go to the facility from the one which referred you here?	Self.....A Husband .....B Parents .....C Parents-in-law.....D Son/daughter .....E Brother/sister .....F Brother-/sister-in-law..... G Other relative .....H FCHV ..... I Outreach health worker .....J Others (Specify) _____.....X	
203	Do you think the decision to come or to send you to this facility for the delivery was taken at the right time?	Yes..... 1 No ..... 2 Wanted to come earlier 3	
204	At what stage (labor pain/complication) did you (or someone else or some other facility) decide you would come/be sent to this facility?	During antenatal complication ..... 1 Before labor pain started ..... 2 Within first 12 hrs. of labor pain ..... 3 After 12 hours of labor pain ..... 4 Following Postpartum complication ..... 5 Others (Specify)_____..... 6	
205	If you come to this facility directly from your home, how long does it take to reach here? **(IF THE RESPONSE IS MORE THAN 59 MINS WRITE IN HOUR, AND IF MORE THAN 23 HOURS WRITE TIME IN DAYS)**	Days..... ☐☐ Hrs. ..... ☐☐ Minutes..... ☐☐ Don't know 98	
206	What mode(s) of transportation did you use to get here?	STRETCHER..... A DOKO ..... B RICKSHAW / BICYCLE. ..... C AUTO VEHICLE ..... D HAND CART/WHEEL BARROW..... E ANIMAL DRIVEN CART/TANGA ..... F AMBULANCE……..G OTHERS (SPECIFY)_____..... X	
207	How much did it cost you to get here? ***(Only include cost incurred for transport)***	Rupees ..... ☐☐☐☐☐ Used own vehicle..... 99995 Don't know..... 99998	

S.N.	Question/Information	Coding Categories	Skip
208	Who accompanied you to this health facility?	Husband ..... A Mother/Father ..... B Mother/Father-in-law ..... C Other family member/relative ..... D Self/no other person ..... E FCHV ..... F Friend/neighbor ..... G Health Worker ..... H Others (Specify) _____ X	
209	What difficulties did you face at home/in the community while taking decision to come to this facility for delivery?	Difficulty obtaining permission from household members ..... A Difficult to find money to cover costs ..... B No one available to accompany ..... C No one for child care ..... D No difficulty ..... Y Others (Specify) _____ X	
210	What difficulties did you face on the way to the facility? (to reach here)	Travel time too long ..... A Difficult to travel ..... B Difficult to find transport Means ..... C Difficult to find money to cover costs ..... D Transportation cost expensive ..... E No one available to accompany ..... F No difficulty ..... Y Others (Specify) _____ X	
211	**Check Q 4** The facility has implemented AAMA program **(Option "1" is circled)** ☐ ↓	The facility has not-implemented AAMA program ☐ → 300 **(Option "2" is circled)**	
212	Are you aware that you are entitled to receive a transport incentive payment because you delivered here?	Yes ..... 1 No ..... 2 → 217	
213	How did you hear about the transport incentive?	Family Members/relative ..... A Friends/neighbors ..... B FCHV ..... C Health Provider ..... D Other Facility staff ..... E Television ..... F Radio/FM ..... G Poster/pamphlet ..... H I/NGO or other community based organizations ..... I Others (Specify) _____ X	
214	What do you think is good about the transport incentive?	Nothing good about it ..... A Covers all costs associated with delivery (e.g. transport) ..... B Encourages women to deliver in facility ..... C Safer care for mother and baby ..... D Saves lives of mothers and babies ..... E Others (Specify) _____ ..... X Don't know ..... Z	

S.N.	Question/Information	Coding Categories	Skip
215	What do you think is not good about the transport incentive provided by the government?	Everything is fine ..... A People not aware of it ..... B Does not benefit poor ..... C Delay in receiving ..... D Do not receive ..... E It is difficult to get it from providers ..... F It is difficult to get full amount/ providers only give some of it ..... G It does not cover all cost incurred for transportation ..... H It does not cover the cost of treating the newborn ..... I It does not cover all costs associated with delivery ..... J Medicines are not free of cost ..... K Laboratory tests are not free ..... L Others (Specify) _____ ..... X Don't know ..... Z	
216	How much should you receive from the transport incentive?	Rupees ..... ☐☐☐☐ Don't know 9998	
217	Have you received any money for your transport incentive from the health facility?	Yes ..... 1 No ..... 2 →	219
218	How much have you received?	Rupees ..... ☐☐☐☐ Don't know 9998	301
219	**IF SHE HAS NOT RECEIVED ANY OR ALL OF THE INCENTIVE** Did the provider say anything regarding receiving the incentive?	Said nothing ..... A Do not have enough money now, will receive later ..... B Concerned person is not here to provide incentive ..... C Asked for identification card ..... D Others (Specify) _____ X	

300. DELIVERY CARE

S.N.	Question/Information	Coding Categories	Skip
301	Why did you decide to deliver in a health facility?	Delivery care is free ..... A Transport incentives ..... B Safer than home delivery ..... C To have a skilled birth attendant ..... D Health worker advised me ..... E Had complication/experienced danger signs (i.e. before arriving at facility) ..... F Female staff ..... G Clients are well treated ..... H Nearby facility ..... I Maintained good reputation for dealing with delivery cases ..... J Others (Specify) _____ X	
302	Did you experience any of the danger signs/had complications before arriving at the facility?	Yes ..... 1 No ..... 2 Don't know 8	304

S.N.	Question/Information	Coding Categories	Skip
303	If yes, what danger signs/ complications did you experience?	Sever headache.....A Blurred vision .....B Severe lower abdominal pain .....C Severe upper abdominal pain……..D Swelling of hand, body or face.....E Any vaginal spotting or bleeding.....F Convulsion/unconsciousness ..... G Labor pain longer than 8 hrs. duration .....H Appearance of baby's hand, leg and placenta first.....I Excessive bleeding before or after delivery.....J Others (Specify) _____... … X No danger sign……Y	
304	During labor, did health worker do anything to speed your labor?	No.....1 Yes, used oxytocin.....2 Yes, but can't say what was done.....3 Don't know 8	
305	**CHECK THE DISCHARGE SLIP AND RECORD MODE OF DELIVERY**	Spontaneous vaginal delivery.....1 → 307 Forceps (instrument to pull baby out) .....2 Vacuum (instrument to suck baby out) ..3 Caesarean Section.....4 Others (Specify) _____.....6	
306	**CHECK THE DISCHARGE SLIP AND NOTE THE INDICATION**	Fetal distress.....A Maternal distress.....B Complete obstruction by fibroid, tumor, ovarian cyst.....C Narrow birth passage(CPD).....D Over sized baby .....E Failure of contraction to progress .....F Previous caesarean section..... G Antepartum Haemorrhage (Placenta praevia or abruption placenta).....H Genital herpes in mother, blood pressure, diabetes, HIV .....I Multiple pregnancy (twins/triplets) ..... J Abnormal fetal presentations (like transverse lie) .....K Others (Specify) _____.....X	
307	Did you/your baby suffer from any complications at the facility? .	**Mother** Fever in mother.....A Pain in lower abdomen or foul smelling discharge .....B Excessive bleeding .....C Severe headache.....D Convulsion/unconsciousness.....E Wound infection of mother .....F **Baby** Neonatal infection .....G Cord infection of baby.....H Others (Specify) _____ X No complication .....Y	

S.N.	Question/Information	Coding Categories	Skip
	Check Q4 The facility has implemented AAMA program **(Option "1" is circled)** ☐ The facility has not-implemented AAMA program **(Option "2" is circled)** ☐ → 401		
	ANSWER FROM THE CARETAKER/RESPONSIBLE PERSON IS ACCEPTABLE.		
308	Did you pay for delivery? **(INFORMATION FROM THE CARETAKER IS ACCEPTABLE)**	Yes ..... 1 No ..... 2 → 311 Don't know ..... 8 → 311	
309	What did you pay for & how much? **(INFORMATION FROM THE CARETAKER IS ACCEPTABLE)**	**Yes** / **No** / **Don't Know** / **If yes, Amount paid in NRs.**	
	1. Registration fee	1 / 2 / 8 / RS ☐☐☐☐☐	
	2. Medicine	1 / 2 / 8 / RS ☐☐☐☐☐	
	3. Delivery/ Operation fee	1 / 2 / 8 / RS ☐☐☐☐☐	
	4. Complication management fee	1 / 2 / 8 / RS ☐☐☐☐☐	
	5. Informal payment to the provider	1 / 2 / 8 / RS ☐☐☐☐☐	
	6. Delivery items required (gloves, sanitary pad, etc.)	1 / 2 / 8 / RS ☐☐☐☐☐	
	7. Bed/Room Fees	1 / 2 / 8 / RS ☐☐☐☐☐	
	8. Cleaning staff tips	1 / 2 / 8 / RS ☐☐☐☐☐	
	9. Others (Specify)_____	1 / 2 / 8 / RS ☐☐☐☐☐	
	10. Suture materials	1 / 2 / 8 / RS ☐☐☐☐☐	
	11. Wound dressing materials during C section	1 / 2 / 8 / RS ☐☐☐☐☐	
	12. Blood transfusion	1 / 2 / 8 / RS ☐☐☐☐☐	
310	**If you paid** Were you told to pay or did you voluntarily offer to pay? **(INFORMATION FROM THE CARETAKER IS ACCEPTABLE)**	Was told to pay ..... 1 Voluntarily offered to pay ..... 2 Both 3	
311	Are you aware that you can get free delivery care at this health facility?	Yes ..... 1 No ..... 2 → 401	
312	How did you hear about free delivery care?	Family Members/relative ..... A Friends/neighbors ..... B FCHV ..... C Health Provider ..... D Facility staff ..... E Television ..... F Radio/FM ..... G Poster/pamphlet ..... H I/NGO or other community based organizations ..... I Others (Specify) _____ X	

S.N.	Question/Information	Coding Categories	Skip
313	**Check Q. 308 & 311 *Respondent has paid for delivery service and is also aware that the delivery care service is free at health facility*** **(Q308 = 1 and Q311 = 1)** ☐	'No' response in either Q308 or Q311 or in both ..... ☐ → 315	
314	You told us that despite knowing about free delivery care you paid for it. Why?	No drugs in stock .....A I was told the facility was short of money .....B I was told I would not get any treatment unless I paid ..... C I was told that free delivery service is not available at this facility ..... D I was told I was not eligible to it because I did not take 4 ANC services .....E Because I was admitted to a cabin .....F I didn't ask ..... G Others (Specify) _____.....X	
315	What do you think is good about free delivery care?	Nothing good about it.....A Financially accessible .....B Encourages women to deliver in facility ..... C Enables poorer women to deliver in facility ..... D Others (Specify) _____.....X Don't know .....Z	
316	What do you think is not good about free delivery care provided by the government?	Everything is fine.....A People not aware of it .....B Does not benefit poor..... C Medicines are not free of cost..... D Staff still charge for services.....E Others (Specify) _____.....X Don't know .....Z	

400. QUALITY OF CARE

S.N.	Question/Information	Coding Categories	Skip
401	How long did you have to wait from when you first arrived until you were first assessed by a provider? **(IF THE RESPONSE IS THAN 59 MINUTES OR LESS , WRITE TIME IN MINUTES AND 00 IN HOUR; OTHERWISE WRITE BOTH HOURS AND MINUTES)**	☐☐ . ☐☐ **Hrs. Minute** Don't know……..98	
402	How satisfied were you about the waiting time? **Read all statements, circle only one** 1) I am very satisfied with the waiting time.....1 2) I am more or less satisfied with the waiting time .....2 3) I am not satisfied with the waiting time 3		
403	Who assisted to deliver your baby?	Doctor .....1 Nurse/ANM .....2 Health Assistant/AHW/Sr. AHW .....3 Others (Specify)_____ .....6 Don't know.....8	

S.N.	Question/Information	Coding Categories	Skip
404	What was the sex of the provider who assisted the delivery of your baby at the health facility?	Male.....1 Female.....2 → 406	
405	If male, would you have preferred a female health staff?	Yes, I would have preferred a female health staff.....1 No I was comfortable 2	
406	At anytime during your care, did you request a companion (e.g. friend/ family member etc) to join you?	Yes .....1 No .....2 → 408	
407	Did the health provider allow to have your companion (e.g. friend / family member / FCHV) with you during the delivery and/or afterwards?	No ..... A Yes – during labor ..... B Yes – during delivery..... C Yes – after delivery..... D Yes – during treatment ..... E	
408	After how long of the birth of your baby did you initiate breastfeeding?	Within..... ☐☐☐☐ minutes Don't know.....9998	
409	Before initiating breastfeeding, did you give your baby any pre- lacteal feed?	Yes .....1 No 2	
410	Did the provider put chlorhexidine (navi malam) in the baby's umbilicus?	Yes .....1 No .....2 Don't know.....8	
411	At the time of discharge did the health staff check/advise the following on both mother and baby?		

	Yes	No	Don't know
Mother			
1. Check BP	1	2	8
2. Check pulse	1	2	8
3. Check temperature	1	2	8
4. Check leg for tenderness/swelling	1	2	8
5. Inspect perineum for tear, bleeding, swelling	1	2	8
6. Examine breast for retracted nipple, cracked nipple, engorgement	1	2	8
7. Ask she has passed urine without difficulties.....	1	2	8
8. Uterine consistency	1	2	8
9. Bleeding.....	1	2	8
10. Cord care advise.....	1	2	8
11. Breastfeeding advise	1	2	8
12. Family Planning advise.....	1	2	8
13. Post Natal Care (PNC) check up advise	1	2	8
14, Carried out wound site examination (e.g. after C section/episiotomy)…….	1	2	8
15. Advised on danger signs during postpartum period.....	1	2	8
Baby			
16. Check baby temperature by touching foot and abdomen.....	1	2	8
17. Check any difficulty in breathing, grunting, chest indrawn	1	2	8
18. Assess newborns general appearance color, movement and cry	1	2	8
19. Check umbilical cord for			

S.N.	Question/Information	Coding Categories	Skip
		bleeding and infection ..... 1 2 8 20. Check for pustules on skin ..... 1 2 8 21. Check eye for discharge ..... 1 2 8 22. Look for sign of jaundice in forehead, abdomen, palm, foot ..... 1 2 8 23. Ask if newborn is breastfeeding well ..... 1 2 8 24. Immunization 1 2 8	
412	Who checked/examined you before leaving the health facility?	Doctor ..... 1 Nurse/ANM ..... 2 Health Assistant/AHW/Sr AHW ..... 3 Others (Specify)_____ ..... 6 Don't know 8	
413	Who checked/examined the baby before leaving the health facility?	Doctor ..... 1 Nurse/ANM ..... 2 Health Assistant/AHW/Sr AHW ..... 3 Others (Specify)_____ ..... 6 Don't know 8	
414	Did you ask any question to the provider?	Yes ..... 1 No 2	
415	How satisfied are you with the information you received from the providers? **Read all statements, circle only one** 1) I am very satisfied with the information I received ..... 1 2) I am fairly satisfied with the information I received ..... 2 3) I am neither satisfied nor dissatisfied (neutral) with the information I received ..... 3 4) I am fairly dissatisfied with the information I received ..... 4 5) I am very dissatisfied with the information I received 5		
416	How satisfied are you with the level of skill the provider had to deliver your baby? **Read all statements, circle only one** 1) I am very satisfied with the level of skill of the provider ..... 1 2) I am fairly satisfied with the level of skill of the provider ..... 2 3) I am neither satisfied nor dissatisfied (neutral) with the level of skill of the provider .. 3 4) I am fairly dissatisfied with the level of skill of the provider ..... 4 5) I am very dissatisfied with the level of skill of the provider 5		
417	Did any of the staff scold you / treat you disrespectfully?	Yes ..... 1 No 2	
418	How satisfied are you with the politeness and empathy of the staff with whom you consulted? **Read all statements, circle only one** 1) I am very satisfied with their politeness ..... 1 2) I am fairly satisfied with their politeness ..... 2 3) I am neither satisfied nor dissatisfied (neutral) with their politeness ..... 3 4) I am fairly dissatisfied with the their politeness ..... 4 5) I am very dissatisfied with their politeness 5		
419	How satisfied are you with the cleanliness of the facility? **Read all statements, circle only one** 1) I am very satisfied with the cleanliness in facility ..... 1 2) I am fairly satisfied with the cleanliness in facility ..... 2 3) I am neither satisfied nor dissatisfied (neutral) with the cleanliness in facility ..... 3 4) I am fairly dissatisfied with cleanliness in the facility ..... 4 3) I am very dissatisfied with the cleanliness in the facility 5		

S.N.	Question/Information	Coding Categories			Skip
420	Were the following things in place to maintain your privacy?	**Yes**	**No**	**Don't know**	
	1. Delivered in separate room?	1	2	8	
	2. Are there curtains on windows (including any openings in the door)	1	2	8	
	3. Divider between beds?	1	2	8	
	4. Curtain between/around beds?	1	2	8	
	5. Others (Specify) _____	1	2		
421	How satisfied are you with the level of privacy you received? **Read all statements, circle only one** 1) I am very satisfied with the level of privacy I received in facility .....1 2) I am fairly satisfied with the level of privacy I received in facility .....2 3) I am neither satisfied nor dissatisfied (neutral) with the level of privacy I received in facility .....3 4) I am fairly dissatisfied with the level of privacy I received in facility.....4 5) I am very dissatisfied with the level of privacy I received in facility.....5				
422	Were you able to get a bed in the facility?	Yes,..... 1 Yes, but sharing with other patient ..... 2 No ..... 3 →			424
423	If yes, how long did you have to wait to get a bed? **(IF THE RESPONSE IS 59 MINUTES or LESS, WRITE TIME IN MINUTES AND 00 IN HOUR; OTHERWISE WRITE BOTH HOURS AND MINUTES)**	Time..... ☐☐ Hrs: ☐☐ Minutes			
424	Was drinking water available in health facility?	Yes..... 1 No 2			
425	Were you able to use the toilet in the facility when needed?	Yes..... 1 No 2			
426	Was this your first delivery?	Yes..... 1 → No 2			430
427	**If this is not first delivery** Where did you deliver your previous child?	Health facility ..... 1 Home ..... 2 On the way..... 3 Others (Specify) _____ 6			429
428	**If first child was delivered at a facility** In which facility did you deliver your previous child?	This facility ..... 1 Public hospital..... 2 PHCC..... 3 Health Post ..... 4 Sub-Health Post..... 5 Private Clinic..... 6 Private/Teaching Hospital..... 7 NGO/missionary ..... 8 Others (Specify) _____ 96			
429	Did you find any differences in the quality of services in this delivery as compared to previous deliveries?	No difference .....A Cost less .....B Cost more .....C Better care .....D Worse care.....E Better staff behavior.....F Worse staff behavior..... G Cleaner/more hygienic.....H Less clean/hygienic ..... I Provision of free medicine ..... J Others (Specify) _____ X			

S.N.	Question/Information	Coding Categories	Skip
432	How satisfied are you with the care you received at this facility? **Read all statements, circle only one** 1) I am very satisfied with the care I received in this facility.....1 2) I am fairly satisfied with the care I received in this facility.....2 3) I am neither satisfied nor dissatisfied (neutral) with the care I received in this facility.....3 4) I am fairly dissatisfied with the care I received in this facility.....4 5) I am very dissatisfied with the care I received in this facility.....5		
433	Would you deliver at this facility again?	Yes..... 1 No ..... 2 Do not intend to have anymore children ..... 3 Don't know 8	
434	Would you recommend others (your friends and family member/relative) to deliver at this facility?	Yes..... 1 No ..... 2 Don't know 8	
435	What are the main improvements that you think this health facility should make?	Staff should be helpful .....A Staff should have good behavior .....B Staff should be competent/skilled.....C Should take steps to reduce waiting time.....D Should discharge clients on time.....E Should Provide incentives on time .....F Should not charge for items..... G Should provide free service .....H Should provide free blood transfusion service..... I Should make the facility clean/ hygienic..... J Should make more beds available .....K Should make bed linen available ..... L Should work on maintenance of privacy..... M Service provider should be male .....N Service provider should be female ..... O Should be nearer .....P Should have room heating facility in the delivery room ..... Q Nothing to improve.....Y Others (Specify)_____.....X	

S.N.	Question/Information	Coding Categories	Skip
436	**CHECK THE DISCHARGE SLIP AND RECORD TIME OF DELIVERY**	Date. . ☐☐ ☐☐ ☐☐☐☐ Day Month Year Time (24 hrs format) ..... ☐☐ . ☐☐ HH MM	
437	**CHECK THE DISCHARGE SLIP AND RECORD THE WEIGHT OF THE BABY WHEN HE/SHE WAS DELIVERED**	☐☐ KG. ..... ☐☐☐ Gram	
438	Irrespective of the outcome, how many times have you been pregnant so far?	☐☐	
439	Irrespective of the outcome, how many deliveries (beyond 22 weeks of gestation age) have you had so far?	Number of deliveries ..... ☐☐	
440	If Q438 has '1' Ask this question cautiously: How many of these births were live birth and how many were still birth?	a. Still birth ..... ☐☐ b. Live birth ..... ☐☐	
441	**RECORD THE TIME TOF INTERVIEW ENDED**	☐☐ . ☐☐ HH MM	
Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!			
Interviewer's comments:			

Nepal Health Facility Survey 2015
Health Facility Operation and Management Committee (HFOMC) Member
OR
Hospital Development Committee (HDC) Member

Interview Questionnaire

GENERAL INFORMATION	
District name _____	
VDC/Municipality	
Name of health facility _____ Code no.	☐☐☐☐
Respondent's serial number……	☐
Note: If no respondent enter 0	
Type of health facility _____ Code no.	☐☐
1 = Central Govt. Hospital 2 = Regional Govt. Hospital 3 = Sub-regional Govt. Hospital 4 = Zonal Govt. Hospital 5 = District Govt. Hospital 7 = Primary Health Care Center (PHCC) 8 = Health Post (HP) 9 = Sub-Health Post (SHP)	
Position of the respondent.....	☐
1=Chairperson 2= Member	
Sex (1 = Male 2 = Female).....	☐

INTERVIEWER VISITS	
Date	☐☐ ☐☐ 2015 DD MM YY
Interviewer's name _____ Code no.	☐☐

READ TO RESPONDENT:

Namaste ! My name is _____. We are conducting a national level health facility faiclities survey for the Ministry of Health and Population, Nepal. This suvey is being conducted by NEW ERA, which is a research organization based in Kathmandu. The survey aims to assist the government in knowing more about health services in NEPAL for planning service improvement. In this context, we are also interviewing representatives of Health Facility Operation and Management Committee (HFOMC)/Hospital Development Committee (HDC) in order to understand the committee's role in health facility operation and management. Information from this interview will be used by Ministry of Health and Population, Nepal for analysis. However, your name and the information provided by you will remain completely confidential.

Please know that whether or not you decide to allow me to interview you, is completely voluntary and if at any point you would prefer I leave, Please feel free to tell me.

100. Do you have any questions for me at this time? Do I have your permission to ask you questions?

Yes……..1 No……2 END INTERVIEW

_____
Interviewer's signature
(Indicates respondent's willingness to participate)

1.0 BACKGROUND

S.N.	Question/Information	Coding Categories	Skip
101	May I begin the interview now?	Agrees .....1 Client refuses.....2 → End	
102	RECORD THE TIME OF INTERVIEW STARTED	☐☐ : ☐☐ HOURS MINUTES USE 24 Hrs FORMAT	
103	Since how many years/months are you associated with this committee? **(Completed years/months)**	No of year in the committee ☐☐ Month ☐☐	
104	What is your caste/ethnicity?	Brahmin/Chhettri..... 1 Terai Madhesi other castes ..... 2 Dalit ..... 3 Newar ..... 4 Janajati ..... 5 Muslim ..... 6 Others..... 96	
105	How old are you? **(Age in completed years)**	Age completed..... ☐☐ Don't know 98	
106	Have you ever attended school?	Yes ..... 1 No..... 2 → 108	
107	What is the highest level of school you attended ?	Highest grade completed* ..... ☐☐	

Codes for Grades

00 = Not passed grade I
01-09 = Grade 1 to 9 passed
10 = SLC passed
11 = Passed proficiency certificate
12 = Passed Bachelor degree
13 = Passed Master or higher degree

	CHECK Q107 GRADE 5 OR LOWER ☐ ↓	GRADE 6 OR HIGHER ☐ → 201	
108	Now I would like you to read this sentence to me **SHOW CARD TO RESPONDENT** **IF RESPONDENT CANNOT READ WHOLE SENTENCE, PROBE** Can you read any part of the sentence to me?	Cannot read at all.....1 Able to read only parts of sentences .....2 Able to read whole sentence .....3 No card with required language _____ ....4 (Specify language) Blind/visually impaired 5	

2.0 Composition, Training and Knowledge

Q.N.	Questions	Coding Categories			Skip
201	**ASK ONLY FOR HDC / HFOMC** How are you represented in the HDC/HFOMC? or which body/organization do you represent?	**HDC** Concerned Mayor or President of the Municipality or VDC where the hospital is located ..... 1 Representative of District Development Committee (DDC) ..... 2 Officer level representative of District Administration Officer ..... 3 Chairperson of Chamber of Commerce and industry ..... 4 President of the District Red Cross Society ..... 5 Women representative from concerned ward where the hospital is located ..... 6 Committee nominated female health Worker .... 7 Medical Superintendent of the hospital ..... 8 **HFOMC** **PHC** DDC Secretary ..... 11 Female representative nominated by VDC ..... 12 DDC member responsible for health services .. 13 DDC member representative selected by DDC 14 Headmaster/Campus head/ nominated by DDC ..... 15 FCHV nominated by DDC ..... 16 Dalit/ janjati representative nominated by HFOMC ..... 17 Dalit/ janjati (female) representative nominated by HFOMC ..... 18 Social worker/reputed person nominated by DDC ..... 19 DHO/DPHO head ..... 20 VDC secretary ..... 21 PHC Incharge ..... 22 **SHP and HP** VDC Secretary ..... 31 Female representative from ward ..... 32 VDC member responsible for health services ... 33 School headmaster nominated by VDC ..... 34 FCHV nominated by VDC ..... 35 Dalit/ janajati representative nominated by HFOMC ..... 36 Dalit/ janajati (female) representative nominated by HFOMC ..... 37 Social worker/reputed person (female) nominated by VDC ..... 38 Health Post Incharge ..... 39 None of the above 0			
202	Have you received or attended any training/orientation/refresher on any of the topics related to HFOMC/HDC?	Yes ..... 1 No ..... 2 →			204
203A	**ASK ONLY FOR HFOMC** If yes, Was the training, orientation or refresher training within the past 24 months or more than 24 months ago?	1. Yes, within past 24 months	2. Yes over 24 months	3. Don't know	
1	Orientation on health facility handover and operation	1	2	8	
2	Local Health Facility Operation and Management Committee's Capacity Building Training	1	2	8	
3	Review workshop	1	2	8	
4	Others (Specify)_____	1	2	8	
203B	**ASK ONLY FOR HDC** If yes, Was the training, orientation or refresher	Yes, within past 24 months 1			

Q.N.	Questions	Coding Categories	Skip
	training within the past 24 months or more than 24 months ago?	Yes over 24 months ..... 2 Don't know 8	

204	In your opinion, what are the responsibilities of the committee (HFOMC/HDC) members?	Yes	No	DK
01	Staffs Management (e.g. ensure the sanctioned post)	1	2	8
02	Manage physical infrastructure in health facility	1	2	8
03	Management of drugs and logistics	1	2	8
04	Identification and mobilization of resources (e.g budget allocated at VDC, DDC, HF, community participation etc.)	1	2	8
05	Planning/implementation/monitoring of health facility services	1	2	8
06	Communication coordination and support with stakeholders related to health facility services	1	2	8
07	Organize regular meeting	1	2	8
08	Encourage and motivate FCHVs	1	2	8
09	Display Citizen charter in health facility	1	2	8
10	Ensure the participation of dalit and backwards in health facility activities	1	2	8
11	Progress review	1	2	8
12	Conduct financial audit	1	2	8
13	Organize social audit	1	2	8
14	Appraisal of staff performance	1	2	8
15	Management and support of PHC/ORC and EPI clinic	1	2	8
16	Regular monitoring of EPI clinic	1	2	8
17	Addressing community grievances/feedbacks	1	2	8
18	Monitoring facility opening and closing time	1	2	8
19	Approval of leave for health facility staff up to 7 days	1	2	8
20	Make short/long term plan for hospital management	1	2	8
21	Revise/fix service charges if any	1	2	8
22	Preparation of yearly report and submission to the government	1	2	8
23	Others (Specify) _____	1	2	8

205	Do you have a booklet/guideline in which roles and responsibilities of HFOMC/HDC committees are written?	Yes ..... 1 No 2	
206	Can you tell us about the types of services provided from this health facility? ***Record all responses mentioned.***	Child vaccination services, either at the facility or as outreach ..... A Growth monitoring services, either at the facility or as outreach ..... B Curative care service for children <5 either at facility or as outreach ..... C Family planning service ..... D ANC services ..... E PMTCT services ..... F Delivery and Newborn care ..... G Diagnosis or treatment of malaria ..... H Diagnosis prescription of STI excluding HIV ..... I Diagnosis prescription or treatment of TB ..... J HIV testing and counseling service ..... K HIV/AIDS antiretroviral prescription or antiretroviral treatment follow-up services ..... L HIV/AIDS care and support services ..... M Diagnosis or management of non-communicable diseases ..... N Minor surgical services ..... O Cesarean delivery ..... P Laboratory diagnostic service ..... Q Blood typing service ..... R Blood transfusion service ..... S Diagnosis or treatment of Kalaazar/Leishmaniasis ..... T Management of snake bite ..... U Management of dog bite/rabies V	

3.0 Participation

Q.N.	Questions	Coding Categories	Skip
301	In the last 3 months, Did this committee conduct any meetings?	Yes ..... 1 No ..... 2 Don't know 8	304
302	How many meeting did you attend in the last 3 months?	No. of meeting ..... ☐☐ No meeting 0	304
303	In the last three months, did you ever put any agenda for discussion in the committee (HFOMC/HDC) meeting?	Yes ..... 1 No 2	
304	In the last meeting of the committee, were you timely informed about meetings date and time?	Yes ..... 1 No 2	
305	Were meeting agenda shared before hand?	Yes ..... 1 No 2	

306	In the last fiscal year (2070-2071), were you engaged in any of the following activities as a HFOMC/HDC member?	Yes	No	DK
01	Staffs Management (e.g. ensure the sanctioned post)	1	2	8
02	Manage physical infrastructure in health facility	1	2	8
03	Management of drugs and logistics	1	2	8
04	Identification and mobilization of resources (e.g budget allocated at VDC, DDC, HF, community participation etc.)	1	2	8
05	Planning/implementation/monitoring of health facility services	1	2	8
06	Communication coordination and support with stakeholders related to health facility services	1	2	8
07	Organize regular meeting	1	2	8
08	Encourage and motivate FCHVs	1	2	8
09	Display Citizen charter in health facility	1	2	8
10	Ensure the participation of dalit and backwards in health facility activities	1	2	8
11	Progress review	1	2	8
12	Conduct financial audit	1	2	8
13	Organize social audit	1	2	8
14	Appraisal of staff performance	1	2	8
15	Management and support of PHC/ORC and EPI clinic	1	2	8
16	Regular monitoring of EPI clinic	1	2	8
17	Addressing community grievances/feedbacks	1	2	8
18	Monitoring facility opening and closing time	1	2	8
19	Approval of leave for health facility staff up to 7 days	1	2	8
20	Make short/long term plan for hospital management	1	2	8
21	Revise/fix service charges if any	1	2	8
22	Preparation of yearly report and submission to the government	1	2	8
23	Others (Specify) _____	1	2	8

4.0 Observation

Q.N.	Questions	Coding Categories	Skip
401	HFOMC/HDC members' name and contacts are displayed/available in health facility.	Yes ..... 1 No 2	

Facility No.:_____ Team No.:_____

Facility Name:_____ Closing Date:_____

	TOTAL NUMBER OF HEALTH WORKERS INTERVIEWED	TOTAL NUMBER OF OBSERVATIONS/EXITS ADMINISTERED				
		ANC	FAMILY PLANNING	SICK CHILD	HFOMC / HDC	PP EXIT
TOTAL (FROM INVENTORY QUESTIONNAIRE) →						

	HEALTH WORKER SERIAL NUMBER (Staff Listing Form)	TOTAL NUMBER OF OBSERVATIONS/EXITS ASSOCIATED WITH LISTED HEALTH WORKERS				
		ANC	FAMILY PLANNING	SICK CHILD	PP	NOTE

STAFF LISTING FORM: HEALTH WORKERS AVAILABLE ON DAY OF VISIT

FACILITY NUMBER ☐☐☐☐☐ **TOTAL NUMBER OF PROVIDERS LISTED ON ALL 5 SHEETS** ☐☐ **INTERVIEWER CODE** ☐☐☐

LIST ALL CLINICAL STAFF / PROVIDERS WHO ARE PRESENT TODAY IN THIS FACILITY. COMPILE THIS LIST AS THE TEAM MOVES FROM ONE SERVICE AREA (OR DEPARTMENT) TO ANOTHER OBTAINING INFORMATION ON THE SERVICES THAT THE FACILITY PROVIDES AND FOR WHICH INVENTORY SECTIONS ARE BEING COMPLETED, AND/OR FOR WHICH CLIENT-PROVIDER OBSERVATIONS ARE BEING DONE. WRITE THE HEALTH WORKER'S QUALIFICATION CODE IN **COLUMN 3 "PROVIDER QUALIFICATION CODE",** AND THE PROVIDER'S GENDER UNDER COLUMN 4 **"GENDER".** PUT CHECK MARKS IN THE APPROPRIATE HEADINGS UNDER **COLUMN 5 "SERVICES PROVIDED IN FACILITY"** TO INDICATE THE SERVICE THAT THE PROVIDER PROVIDES IN THE FACILITY. IN **COLUMN 6 "INTERVIEWED FOR INVENTORY"**, CIRCLE THE LINE NUMBER IF THE PROVIDER WAS INTERVIEWED FOR ANY SECTION OF THE INVENTORY QUESTIONNAIRE. FINALLY, IN **COLUMN 7 "SELECTED FOR HEALTH WORKER INTERVIEW"** CIRCLE THE LINE NUMBER IF THE PROVIDER IS SELECTED TO BE INTERVIEWED WITH THE INDIVIDUAL HEALTH WORKER QUESTIONNAIRE.

(1)	(2)	(3)		(4)	(5)															(6)	(7)
					SERVICES PROVIDED IN FACILITY																
							DIAGNOSIS/TREATMENT														
PROV SERIAL NUMBER	NAME OF PROVIDER	PROVIDER QUALIFICATION CODE		GENDER	PRESCRIBE ART	HIV COUNSELING AND TESTING	HIV/AIDS RELATED	MALARIA	TB	STI	NCD	ANTENATAL CARE	PMTCT	DELIVERY	FAM PLANNING	CHILD HEALTH	SURGERY	CONDUCT LABORATORY TESTS	OTHER CLIENT SERVICES	INTERVIEWED FOR INVENTORY	SELECTED FOR HEALTH WORKER INTERVIEW
01																				01	01
02																				02	02
03																				03	03
04																				04	04
05																				05	05
06																				06	06
07																				07	07
08																				08	08
09																				09	09
10																				10	10
11																				11	11
12																				12	12
13																				13	13
14																				14	14
15																				15	15
16																				16	16
17																				17	17
18																				18	18
19																				19	19
20																				20	20

PROVIDER QUALIFICATION CATEGORY:

GENERALIST [NON-SPECIALIST] MEDICAL DOCTORS 01
GYNECOLOGIST / OBSTETRICIAN 02
ANESTHESIOLOGIST. 03
PATHOLOGIST. 04
GENERAL SURGEON. 05
PEDIATRICIAN. 06
OTHER SPECIALISTS MEDICAL DOCTORS 07
MEDICAL OFFICER (MBBS, BDS) 08

ANESTHETIC ASSISTANT 09
NURSE (MN, BSC NURSE, BN, PCL) /
AUXILLARY NURSE MIDWIFE (ANM). . . . 10
LABORATORY TECHNOLOGIST/OFFICER
LABORATORY TECHNICIAN
LABORATORY ASSISTANT. 11
HEALTH ASSISTANT (HA) / AHW / SAHW /
PUBLIC HEALTH INSPECTOR. 12

COUNSELOR **WITH** CLINICAL QUALIFICATION (STAND -ALONE HTC ONLY) 16
COUNSELOR **WITHOUT** CLINICAL
QUALIFICATION (STAND -ALONE HTC ONLY). 17
OTHER CLINICAL STAFF NOT LISTED ABOVE 18
NON-CLINICAL STAFF / NO TECHNICAL QUALIFICATION 95

STAFF LISTING FORM: HEALTH WORKERS AVAILABLE ON DAY OF VISIT

FACILITY NUMBER | | | | | |

INTERVIEWER CODE | | | |

LIST ALL CLINICAL STAFF / PROVIDERS WHO ARE PRESENT TODAY IN THIS FACILITY. COMPILE THIS LIST AS THE TEAM MOVES FROM ONE SERVICE AREA (OR DEPARTMENT) TO ANOTHER OBTAINING INFORMATION ON THE SERVICES THAT THE FACILITY PROVIDES AND FOR WHICH INVENTORY SECTIONS ARE BEING COMPLETED, AND/OR FOR WHICH CLIENT-PROVIDER OBSERVATIONS ARE BEING DONE. WRITE THE HEALTH WORKER'S QUALIFICATION CODE IN **COLUMN 3 "PROVIDER QUALIFICATION CODE",** AND THE PROVIDER'S GENDER UNDER COLUMN 4 **"GENDER".** PUT CHECK MARKS IN THE APPROPRIATE HEADINGS UNDER **COLUMN 5 "SERVICES PROVIDED IN FACILITY"** TO INDICATE THE SERVICE THAT THE PROVIDER PROVIDES IN THE FACILITY. IN **COLUMN 6 "INTERVIEWED FOR INVENTORY"**, CIRCLE THE LINE NUMBER IF THE PROVIDER WAS INTERVIEWED FOR ANY SECTION OF THE INVENTORY QUESTIONNAIRE. FINALLY, IN **COLUMN 7 "SELECTED FOR HEALTH WORKER INTERVIEW"** CIRCLE THE LINE NUMBER IF THE PROVIDER IS SELECTED TO BE INTERVIEWED WITH THE INDIVIDUAL HEALTH WORKER QUESTIONNAIRE.

(1)	(2)	(3)		(4)	(5)															(6)	(7)
					SERVICES PROVIDED IN FACILITY																
PROV SERIAL NUMBER	NAME OF PROVIDER	**PROVIDER QUALIFICATION CODE**		**GENDER**	PRESCRIBE ART	HIV COUNSELING AND TESTING	DIAGNOSIS/TREATMENT					ANC	PMTCT	DELIVERY	FAM PLANNING	CHILD HEALTH	SURGERY	CONDUCT LABORATORY TESTS	OTHER CLIENT SERVICES	**INTERVIEWED FOR INVENTORY**	**SELECTED FOR HEALTH WORKER INTERVIEW**
							HIV/AIDS RELATED	MALARIA	TB	STI	NCD										
21																				21	21
22																				22	22
23																				23	23
24																				24	24
25																				25	25
26																				26	26
27																				27	27
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36																				36	36
37																				37	37
38																				38	38
39																				39	39
40																				40	40

PROVIDER QUALIFICATION CATEGORY:

GENERALIST [NON-SPECIALIST] MEDICAL DOCTORS 01
GYNECOLOGIST / OBSTETRICIAN 02
ANESTHESIOLOGIST. 03
PATHOLOGIST. 04
GENERAL SURGEON. 05
PEDIATRICIAN. 06
OTHER SPECIALISTS MEDICAL DOCTORS 07
MEDICAL OFFICER (MBBS, BDS) 08
ANESTHETIC ASSISTANT 09
NURSE (MN, BSC NURSE, BN, PCL) / AUXILLARY NURSE MIDWIFE (ANM). . . . 10
LABORATORY TECHNOLOGIST/OFFICER LABORATORY TECHNICIAN LABORATORY ASSISTANT. 11
HEALTH ASSISTANT (HA) / AHW / SAHW / PUBLIC HEALTH INSPECTOR. 12
COUNSELOR **WITH** CLINICAL QUALIFICATION (STAND -ALONE HTC ONLY) 16
COUNSELOR **WITHOUT** CLINICAL QUALIFICATION (STAND -ALONE HTC ONLY). 17
OTHER CLINICAL STAFF NOT LISTED ABOVE 18
NON-CLINICAL STAFF / NO TECHNICAL QUALIFICATION 95

STAFF LISTING FORM: HEALTH WORKERS AVAILABLE ON DAY OF VISIT

FACILITY NUMBER | | | | | |

INTERVIEWER CODE | | | |

LIST ALL CLINICAL STAFF / PROVIDERS WHO ARE PRESENT TODAY IN THIS FACILITY. COMPILE THIS LIST AS THE TEAM MOVES FROM ONE SERVICE AREA (OR DEPARTMENT) TO ANOTHER OBTAINING INFORMATION ON THE SERVICES THAT THE FACILITY PROVIDES AND FOR WHICH INVENTORY SECTIONS ARE BEING COMPLETED, AND/OR FOR WHICH CLIENT-PROVIDER OBSERVATIONS ARE BEING DONE. WRITE THE HEALTH WORKER'S QUALIFICATION CODE IN **COLUMN 3 "PROVIDER QUALIFICATION CODE",** AND THE PROVIDER'S GENDER UNDER COLUMN 4 **"GENDER".** PUT CHECK MARKS IN THE APPROPRIATE HEADINGS UNDER **COLUMN 5 "SERVICES PROVIDED IN FACILITY"** TO INDICATE THE SERVICE THAT THE PROVIDER PROVIDES IN THE FACILITY. IN **COLUMN 6 "INTERVIEWED FOR INVENTORY"**, CIRCLE THE LINE NUMBER IF THE PROVIDER WAS INTERVIEWED FOR ANY SECTION OF THE INVENTORY QUESTIONNAIRE. FINALLY, IN **COLUMN 7 "SELECTED FOR HEALTH WORKER INTERVIEW"** CIRCLE THE LINE NUMBER IF THE PROVIDER IS SELECTED TO BE INTERVIEWED WITH THE INDIVIDUAL HEALTH WORKER QUESTIONNAIRE.

(1)	(2)	(3)	(4)	(5)															(6)	(7)
				SERVICES PROVIDED IN FACILITY																
PROV SERIAL NUMBER	NAME OF PROVIDER	PROVIDER QUALIFICATION CODE	GENDER	PRESCRIBE ART	HIV COUNSELING AND TESTING	DIAGNOSIS/TREATMENT					ANC	PMTCT	DELIVERY	FAM PLANNING	CHILD HEALTH	SURGERY	CONDUCT LABORATORY TESTS	OTHER CLIENT SERVICES	INTERVIEWED FOR INVENTORY	SELECTED FOR HEALTH WORKER INTERVIEW
						HIV/AIDS RELATED	MALARIA	TB	STI	NCD										
41																			41	41
42																			42	42
43																			43	43
44																			44	44
45																			45	45
46																			46	46
47																			47	47
48																			48	48
49																			49	49
50																			50	50
51																			51	51
52																			52	52
53																			53	53
54																			54	54
55																			55	55
56																			56	56
57																			57	57
58																			58	58
59																			59	59
60																			60	60

PROVIDER QUALIFICATION CATEGORY:

GENERALIST [NON-SPECIALIST] MEDICAL DOCTORS 01
GYNECOLOGIST / OBSTETRICIAN 02
ANESTHESIOLOGIST. 03
PATHOLOGIST. 04
GENERAL SURGEON. 05
PEDIATRICIAN. 06
OTHER SPECIALISTS MEDICAL DOCTORS 07
MEDICAL OFFICER (MBBS, BDS) 08
ANESTHETIC ASSISTANT 09
NURSE (MN, BSC NURSE, BN, PCL) / AUXILLARY NURSE MIDWIFE (ANM). . . . 10
LABORATORY TECHNOLOGIST/OFFICER LABORATORY TECHNICIAN LABORATORY ASSISTANT. 11
HEALTH ASSISTANT (HA) / AHW / SAHW / PUBLIC HEALTH INSPECTOR. 12
COUNSELOR **WITH** CLINICAL QUALIFICATION (STAND -ALONE HTC ONLY) 16
COUNSELOR **WITHOUT** CLINICAL QUALIFICATION (STAND -ALONE HTC ONLY). 17
OTHER CLINICAL STAFF NOT LISTED ABOVE 18
NON-CLINICAL STAFF / NO TECHNICAL QUALIFICATION 95

STAFF LISTING FORM: HEALTH WORKERS AVAILABLE ON DAY OF VISIT

FACILITY NUMBER | | | | | |

INTERVIEWER CODE | | | |

LIST ALL CLINICAL STAFF / PROVIDERS WHO ARE PRESENT TODAY IN THIS FACILITY. COMPILE THIS LIST AS THE TEAM MOVES FROM ONE SERVICE AREA (OR DEPARTMENT) TO ANOTHER OBTAINING INFORMATION ON THE SERVICES THAT THE FACILITY PROVIDES AND FOR WHICH INVENTORY SECTIONS ARE BEING COMPLETED, AND/OR FOR WHICH CLIENT-PROVIDER OBSERVATIONS ARE BEING DONE. WRITE THE HEALTH WORKER'S QUALIFICATION CODE IN **COLUMN 3 "PROVIDER QUALIFICATION CODE",** AND THE PROVIDER'S GENDER UNDER COLUMN 4 **"GENDER".** PUT CHECK MARKS IN THE APPROPRIATE HEADINGS UNDER **COLUMN 5 "SERVICES PROVIDED IN FACILITY"** TO INDICATE THE SERVICE THAT THE PROVIDER PROVIDES IN THE FACILITY. IN **COLUMN 6 "INTERVIEWED FOR INVENTORY"**, CIRCLE THE LINE NUMBER IF THE PROVIDER WAS INTERVIEWED FOR ANY SECTION OF THE INVENTORY QUESTIONNAIRE. FINALLY, IN **COLUMN 7 "SELECTED FOR HEALTH WORKER INTERVIEW"** CIRCLE THE LINE NUMBER IF THE PROVIDER IS SELECTED TO BE INTERVIEWED WITH THE INDIVIDUAL HEALTH WORKER QUESTIONNAIRE.

(1)	(2)	(3)	(4)	(5)															(6)	(7)
				SERVICES PROVIDED IN FACILITY																
PROV SERIAL NUMBER	NAME OF PROVIDER	**PROVIDER QUALIFICATION CODE**	**GENDER**	PRESCRIBE ART	HIV COUNSELING AND TESTING	DIAGNOSIS/TREATMENT					ANC	PMTCT	DELIVERY	FAM PLANNING	CHILD HEALTH	SURGERY	CONDUCT LABORATORY TESTS	OTHER CLIENT SERVICES	**INTERVIEWED FOR INVENTORY**	**SELECTED FOR HEALTH WORKER INTERVIEW**
						HIV/AIDS RELATED	MALARIA	TB	STI	NCD										
61																			**61**	**61**
62																			**62**	**62**
63																			**63**	**63**
64																			**64**	**64**
65																			**65**	**65**
66																			**66**	**66**
67																			**67**	**67**
68																			**68**	**68**
69																			**69**	**69**
70																			**70**	**70**
71																			**71**	**71**
72																			**72**	**72**
73																			**73**	**73**
74																			**74**	**74**
75																			**75**	**75**
76																			**76**	**76**
77																			**77**	**77**
78																			**78**	**78**
79																			**79**	**79**
80																			**80**	**80**

PROVIDER QUALIFICATION CATEGORY:

GENERALIST [NON-SPECIALIST] MEDICAL DOCTORS 01
GYNECOLOGIST / OBSTETRICIAN 02
ANESTHESIOLOGIST. 03
PATHOLOGIST. 04
GENERAL SURGEON. 05
PEDIATRICIAN. 06
OTHER SPECIALISTS MEDICAL DOCTORS 07
MEDICAL OFFICER (MBBS, BDS) 08
ANESTHETIC ASSISTANT 09
NURSE (MN, BSC NURSE, BN, PCL) / AUXILLARY NURSE MIDWIFE (ANM). . . . 10
LABORATORY TECHNOLOGIST/OFFICER LABORATORY TECHNICIAN LABORATORY ASSISTANT. 11
HEALTH ASSISTANT (HA) / AHW / SAHW / PUBLIC HEALTH INSPECTOR. 12
COUNSELOR **WITH** CLINICAL QUALIFICATION (STAND -ALONE HTC ONLY) 16
COUNSELOR **WITHOUT** CLINICAL QUALIFICATION (STAND -ALONE HTC ONLY). 17
OTHER CLINICAL STAFF NOT LISTED ABOVE 18
NON-CLINICAL STAFF / NO TECHNICAL QUALIFICATION 95

STAFF LISTING FORM: HEALTH WORKERS AVAILABLE ON DAY OF VISIT

FACILITY NUMBER | | | | | |

INTERVIEWER CODE | | | |

USE THIS FORM TO COMPILE THE NAMES OF HEALTH WORKERS WHO WORK IN THE FACILITY BUT WHO ARE NOT PRESENT IN THE FACILITY ON THE DAY OF YOUR VISIT. OBTAIN THIS INFORMATION FROM THE FACILITY INCHARGE OR ANOTHER KNOWLEDGEABLE PERSON. THEY MAY BE OUT SICK, NOT ON DUTY THAT DAY, OR ABSENT FOR SOME OTHER REASON. IF THERE IS NOT ENOUGH SPACE TO LIST ALL SUCH PROVIDERS, STOP THE LIST AT 99. WRITE THE HEALTH WORKER'S QUALIFICATION CODE IN COLUMN 3 **"PROVIDER QUALIFICATION CODE",** AND THE GENDER IN COLUMN 4 "**GENDER".** PUT CHECK MARKS IN THE APPROPRIATE HEADINGS IN COLUMN 5 **"SERVICES PROVIDED IN FACILITY"** TO INDICATE THE SERVICE THAT THE PROVIDER PROVIDES IN THE FACILITY. ASK THE INCHARGE TO TELL YOU THE SERVICES THAT THESE PEOPLE PROVIDE AS PART OF THIER WORK IN THE FACILITY.

(1)	(2)	(3)		(4)	(5)															(6)	(7)
					SERVICES PROVIDED IN FACILITY																
							DIAGNOSIS/TREATMENT														
PROV SERIAL NUMBER	NAME OF PROVIDER	**PROVIDER QUALIFICATION CODE**		**GENDER**	PRESCRIBE ART	HIV COUNSELING AND TESTING	HIV/AIDS RELATED	MALARIA	TB	STI	NCD	ANTENATAL CARE	PMTCT	DELIVERY	FAM PLANNING	CHILD HEALTH	SURGERY	CONDUCT LABORATORY TESTS	OTHER CLIENT SERVICES	**INTERVIEWED FOR INVENTORY**	**SELECTED FOR HEALTH WORKER INTERVIEW**
81																				**81**	**81**
82																				**82**	**82**
83																				**83**	**83**
84																				**84**	**84**
85																				**85**	**85**
86																				**86**	**86**
87																				**87**	**87**
88																				**88**	**88**
89																				**89**	**89**
90																				**90**	**90**
91																				**91**	**91**
92																				**92**	**92**
93																				**93**	**93**
94																				**94**	**94**
95																				**95**	**95**
96																				**96**	**96**
97																				**97**	**97**
98																				**98**	**98**
99																				**99**	**99**

PROVIDER QUALIFICATION CATEGORY:

GENERALIST [NON-SPECIALIST] MEDICAL DOCTORS 01
GYNECOLOGIST / OBSTETRICIAN 02
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PATHOLOGIST. 04
GENERAL SURGEON. 05
PEDIATRICIAN. 06
OTHER SPECIALISTS MEDICAL DOCTORS 07
MEDICAL OFFICER (MBBS, BDS) 08

ANESTHETIC ASSISTANT 09
NURSE (MN, BSC NURSE, BN, PCL) /
AUXILLARY NURSE MIDWIFE (ANM). . . . 10
LABORATORY TECHNOLOGIST/OFFICER
LABORATORY TECHNICIAN
LABORATORY ASSISTANT. 11
HEALTH ASSISTANT (HA) / AHW / SAHW /
PUBLIC HEALTH INSPECTOR. 12

COUNSELOR **WITH** CLINICAL QUALIFICATION (STAND -ALONE HTC ONLY) 16
COUNSELOR **WITHOUT** CLINICAL
QUALIFICATION (STAND -ALONE HTC ONLY). 17
OTHER CLINICAL STAFF NOT LISTED ABOVE 18
NON-CLINICAL STAFF / NO TECHNICAL QUALIFICATION 95